CONCERN WORLDWIDE

USAID Child Survival & Health Grants Program
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October 1, 2005 – September 30, 2006

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince

Delmas Commune: St. Martin and Cite Okay-Jeremie
Petion-Ville Commune: Jalousie and Bois de Moquette in
Port-au-Prince Commune: Descayettes

A Partnership of Concern Worldwide, FOCAS, and GRET with the Ministry of Health West Department

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ACRONYM LIST

AED	Academy for Educational Development
AMTSL	Active Management of the Third Stage of Labor
ASON	National Association of People Living with HIV/AIDS
BC	Bureau Communal of the MSPP
CAMEP	Centrale Métropolitaine d'Eau Potable
CDS	Centres pour la Développement et la Santé a Haitian NGO
CSHGP	USAID-funded Child Survival and Health Grants Program
CSSA	CORE/CSTS Sustainability Assessment
CTC	Community-based Therapeutic Care
DHS	Haiti Demographic Health Survey
DIP	Detailed Implementation Plan
DSO	West Health Department of the Ministry of Health
FOCAS	Foundation of Compassionate American Samaritans
FONKOZE	A Haitian micro-finance institution
GENESIS	A Haitian public health management and technical consulting firm
GRAIFSI	Groupe d'Appui pour l'Intégration de la Femme du Secteur Informel
GRET	Groupe de Recherche et d'Echange Technologique
GRIEAL	An organization specializing in education and local development
HMIS	Health management information system
ICF	Interim Cooperation Framework
ID	Initiative Development
IMCI	Integrated Management of Childhood Diseases
IR	Intermediate Results
IAP	Indoor Air Pollution
ISA	Institutional Strengths Assessment
KDSM	Federation of CBOs operating in St. Martin "Kowodinasyon pou Devlopman Sen Maten"
KPC	Knowledge, Practices and Coverage survey
LQAS	Lot Quality Assurance Sampling
MEI	Local NGO "Mission Evangelique Internationale" working in Bois Moquette
MOST	Management and Organizational Sustainability Tool
MSH	Management for Science and Health
MSPP	Ministre de la Santé Publique et de la Population (Ministry of Health)
MUAC	Mid-Upper Arm Circumference measurement
OBDC	Local NGO « Oeuvres de Bienfaisance et Développement Communautaire » working in Jalousie
OR	Operations Studies
ORS	Oral Rehydration Salts
PRAG	Partners Research and Action Group
PROMESS	Essential Medical Supply Store
PSI	Population Services International
SNELAK	Local CBO operating in Descayettes, "SOSYETE NEG LAKAY"
TBAs	Traditional Birth Attendants
UCS	Unités Communales de Santé
WHO	World Health Organization

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Introduction

This is a five-year USAID Child Survival & Health Standard Grant Program led by **Concern Worldwide**, and a strategic partnership with **Groupe de Recherche et d'Echange Technologique (GRET),** and **Foundation of Compassionate American Samaritans (FOCAS).** Together, these three agencies work hand in hand with the Ministry of Health **(MSPP)** at the **Ministry of Health West Department (DSO)** with the aim of improving the health status of vulnerable maternal, child and youth populations living in five disadvantaged urban neighborhoods of Cite Okay/Jeremie, Descayettes, Jalousie, Bois Moquette, and St. Martin of the Port-au-Prince metropolitan area of Haiti.

Over the past 15 years the urban population in Haiti has swelled from 29.5% to 38.8%[i] leaving the urban extreme poor as the fastest growing population in the country. While national health indicators have improved over the past 20 years, the urban areas have been particularly affected by unplanned growth and public service neglect. While elections of February 2006 have brought calm and sense of renewal, on March 2006, UNICEF issued a Child Alert for Haiti, marking it as one of the most challenging places on earth for children. Haiti's biggest cities were spotlighted as traps locking mothers and children into a "perpetual cycle of violence, poverty and abuse that is almost impossible to break."

The strategic objective of the urban health project is sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching about 10 percent of the city's population. The total project population includes 218,490 residents including 32,555 children under five years of age and 53,967 women of reproductive age (15-49 years).

This program focuses on six key interventions which closely match the principle causes of child and maternal mortality: HIV/AIDS (20%), maternal & newborn care (20%), control of diarrheal disease (25%), nutrition (15%), pneumonia case management (10%); and immunizations (10%).

The following intermediate results encompass the strategy and activities required at the household, neighborhood, health service and political level. Together, these will enable the above, long-term goals for improved health to be realized.

IR 1: <u>Empowered communities</u> with increased knowledge and interest in maternal, child and youth health promotion. Working with 5 neighborhood health networks of numerous active and respected CBOs, 1,136 youth leaders, 60 TBAs and health center personnel, build skills to identify needs, develop strategies and actions for health promotion, resource activities, and monitor effectiveness.

IR 2: <u>Enhanced availability of and access</u> to reproductive and child health services for disadvantaged households in urban areas. Working with 5 health facilities, improve availability and management of essential drugs and supplies, leverage availability of subsidized national programs, and learn from cost sharing strategies

IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers. Working with five focal health facilities to develop a quality assurance and monitoring team approach, develop and test models for performance incentives, organize trainings on key skill areas, organize joint NGO/BC supervision on a quarterly basis.

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people. Developing exchange and applied research platform to build evidence and consensus for effective urban health strategies, documenting and disseminating experience, advocating on environmental health intervention by government and donor community, and supporting DSO in initiating an urban health strategy development process.

Note that in all intervention areas, other agencies are providing health facility based HIV services including STI screening, facility based care and support, PMTCT and VCT services, safe blood, etc. Therefore, this project complements them with a strong youth prevention and integration of HIV services with maternal and newborn care. Indicators related to HIV/AIDS health services are excluded from this project scope but the program will contribute to monitoring for complementary projects in the area.

This report summarizes achievements and challenges from the first year of activity and informs the workplan for year two which is attached in annex 1.

A. Major Achievements in Year One

In its first year, the program made some solid advances despite an ongoing insecure working environment. Major achievements identified by the project team included:

- Completion of baseline studies including a KPC survey in all neighborhoods, rapid assessment of the local health services, introductions with CBOs and rapid situation analysis resulting in a better understanding of the health situation and interests in these neighborhoods
- Development of an approved Detailed Implementation Plan (DIP) with the DSO, USAID, and local stakeholders that has been very useful in setting regular workplans and team vision
- Reviewed health information system in private and public health centers, trained staff and agreed on a unified health center reporting formats demonstrating a good focus on the M&E system from the beginning of the project.
- Good working relationship between several operational partners - start meetings, unifying vision and approaches, and better communications. Conducted a joint exchange visit to Bangladesh on social mobilization and C/IMCI.
- While it is still early, there has been a positive initial response by community groups to work together in health promotion, although the youth component remains challenging.

Table 1: Progress by Intermediate Results

Major Activities	STATUS ("Done", "On Track", "Attention")	COMMENTS (facilitating and impeding factors, areas where need assistance, things that need to be discussed changed)	Implications for next year's work
IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion			
Identification and dialogue with youth groups; develop selection process and criteria; develop motivation strategy	On Track but needs more work in the coming year; identification completed in 2 of the 5 neighborhoods	In all neighborhoods working through existing Youth Groups to discuss the concept of developing this new cadre. Selection made through the groups for practical reasons but also adjusted age criteria to 15-30 to reflect the reality of the membership. In Cite Okay 21 Leaders selected, St. Martin 30, Descayettes 25 out of the 50 needed have been selected. Initiative slowed down when recognized partners using different approaches, titles, and roles and agreed that this needs to be uniform. Issues raised about value of participating including strong request for compensation or access to support for school fees. A motivation strategy must be developed and build on the real needs and interests.	Urgently need a motivation strategy and need to look at how other agencies interested in HIV and youth can further support them to make the monthly meetings useful (vocational education, microfinance, culture/art, etc) - not just about health. Training curriculum should be reviewed and endorsed by MSPP so that it is recognized and participants receive certificates. This also helps to raise awareness of our activity and possibly draw in more support.
Youth groups identification of condom distribution points	On track	Completed by Youth Groups in all neighborhoods with exception of FOCAS areas due to PEPFAR restriction where they worked with CBOs instead. Sites need to be verified by project staff. Problem with erratic supply of free condoms from MSPP so will introduce social marketing approach and top supply with free condoms as available. Recognize need to be clear in communicating why some are paid for and others free but that is better than no access.	Need to follow-up with vendor orientation plan and contact PSI regarding institutional support with training and procurement.
Annual action planning with CBOs by neighbourhood	Done in 2 neighborhoods but not in 3 others	Easier to do this activity with KDSM and Pilot Committee as these are already organized bodies with existing plans so it was an updating. Insecurity in Descayettes over past six months made this impossible. Bois Moquette & Jalousie still organising a community body with which to plan.	Continued annual planning.
Set community health forum capacity benchmarks and targets; draft tool design	On track	Process Documentation contracted and developed draft capacity assessment tool which has been shared for feedback. Areas and measures are now incorporated in sustainability framework. Has been slower than planned due to absence of Health Coordinator position for local liaison and difficulty defining exact entities to assess due to varying structures in the neighborhoods.	Need further input from community on the indicators and targets; Will need to complete the asessments in five neighborhoods in next year as baseline.
Selection of Community health education trainers	Postponed	Needed more discussion with the designers on the qualities, role, and support that would be provided to these positions. This has been discussed at the annual review and included in the behavior change section of this report.	Complete selection, orientation and facilitation training.

Major Activities	STATUS ("Done", "On Track", "Attention")	COMMENTS (facilitating and impeding factors, areas where need assistance, things that need to be discussed changed)	Implications for next year's work
IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas			
Water and Sanitation Committees conduct situation analysis on opportunities for public hand washing stations and distribution points for ORS and Pur/Chlorine (JIF)	In Process and Attention	Lack of water supply in many zones of neighborhoods, especially Cite Okay made this analysis difficult. In Tokyo, water committees were chased away by armed bandits - KDSM now looking into the matter. In Descayettes this is working better. Need more clarification and communication about the role of this project in water & sanitation as stated in DIP that we would assist in documenting the situation and seeking other donor support.	Write up findings for proposal for areas that cannot be supported by Concern's Urban Violence program in St. Martin & Cite Okay Continue discussions and promote opportunities to put strategies in place. Mapping should be documented.
Training on Essential Drugs Management	In Process	The module on Managing Drug Stock has been completed in September 2005 with 17 participants from all health centers. However, the MSPP is updating the Rationalization of Drugs module so advised by National Trainer to wait for this part.	Follow progress on update of Rationalization of Drugs module
Capitalization of essential drugs for health centers	In Process and Attention	Unable to procure first stock support as planned as PROMESS has been closed for past few months due to insecurity but due to open any week. In the meantime the HCs are facing tremendous stockouts due to non-access supplies too. Reports of measles and polio vaccine stock-outs at HC and BC level even though there is reported no problem with national supplies. Concern raised this at national EPI meeting with UNICEF/MSPP/ USAID on 9/21 for support.	Close monitoring of re-opening of PROMESS to provide first stock based on tools from essential drug management training in place at Health Centers.
Planning with Dept IMCI trainers	Postponed	Absence of Health Coordinator to engage in arrangements, change in DSO requires familiarization with our activities, and non-availability of key drugs requires us to postpone this training. Central MOH department for Family health just completed the evaluation of the national IMCI programme and plans to make revision to it based on results.	Reassess opportunity to complete IMCI training in 2007
IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers			
Training Health Center Personnel and Project Staff on Health Information System by M&E Consultant	Done	Trained 15 staff (3 per HC) on government HMIS following facility review. Provided standardized reporting tools to all participating HCs. Follow-up performance system under development for 2007	Implement neighborhood HMIS review; ensure collection and use of HC reports by project and BC.

Major Activities	STATUS ("Done", "On Track", "Attention")	COMMENTS (facilitating and impeding factors, areas where need assistance, things that need to be discussed changed)	Implications for next year's work
Establish performance incentives guidelines	In Process and Attention	While FOCAS has existing guidelines and criteria this isn't the case for Concern and GRET. Concern studied options and discussed with the HC a personnel focusing on guaranteeing micro credit loans but this is not viewed as a very strong incentive and could have negative ramifications within the HC staff and with Concern if not repaid. Descayettes is still discussing internally.	Group to review criteria used in FOCAS areas to collaboratively develop exceptional performance recognition standards; Concern needs to reassess incentives approach to ensure that it will do more good than harm. A day of dialogue among CW/GRET/FOCAS is required as well as a firm decision day with appropriate managers.
Complete letters of understanding with roles and performance incentives guidelines with Health Centers and DSO	Attention	Agreement letters delayed due to the problems establishing performance incentives although roles were developed and agreed at the DIP workshops in April 2006.	Model letters to be developed including clause that work amiably on performance incentives approach so that is no further delayed. Should also consider letters for CBOs where appropriate like KDSM, SNELAK.
Solidify ANC screening and referral w/MSF	Postponed	Due to absence of a Health Coordinator discussions have not occurred. Hospital is accepting clients but does not have a clear referral agreement with the participating CS facilities nor a shared screening protocol.	Request support from CW & GRET Directors to follow-up with MSF/Holland to have a clear referral relationship for underserved neighborhoods.
IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.			
Quarterly Urban Platform meetings	Attention	No formal meetings held due to change in DSO and absence of a Health Coordinator. Project staff felt it was too early to initiate.	Request support from CW & GRET Directors to organize introductory meeting, sharing DIP and working together on letter of agreement including clarifying role in platform. Aim for first meeting by Jan 07
Contribute to revision of the national TBA curriculum with MSPP, MSH, UNICEF, and other CS grantees	Attention	Staff having difficulty engaging with MSH focal person on this activity. Team is also very busy and this is not a priority item as they are not being invited to review the document at this stage and TBA training is at least 18 months away.	Follow-up with MSPP and UNICEF for further information about status on how to get involved in the review
Special Studies/Tools			
Nutrition, Livelihoods & Willingness to Pay Survey in 3 Neighborhoods	Attention	Insecurity in Descayettes impeded the survey. Absence of Health Coordinator to negotiate design with contractor further impeding the activity.	Seek support from CW US Health Advisor to work with contractor on protocol and complete survey by early 2007, pending improved security in Descayettes.

Major Activities	STATUS ("Done", "On Track", "Attention")	COMMENTS (facilitating and impeding factors, areas where need assistance, things that need to be discussed changed)	Implications for next year's work
Review KPC data on careseeking and use of informal sector with Platform and CBO Leaders	Done	Findings showed first and second source of careseeking is predominantly the health center (37% and 41%); hospital (30% and 31%). Treatment from friends and relative s is next at 10% and 4%); interestingly use of Traditional healers increases as second source but is still low at 1% and 9% respectively. Use of informal providers, Houngans and Quacks, is reported as less than 1%.	Hold national meeting to disseminate survey report. Share results at community health forum for feedback as part of annual planning.
Mapping health partners w/bureaux communales	In process	Discussions held with BC to plan for activity but not yet completed. Still need to work out exact guidelines.	Priority is mapping for Cite Okay

B. Challenges/impediments and actions taken

The project team faced several challenges while implementing the project plan due to both external and internal causes. The following table was developed by the team to analyze the major issues that hindered progress, what actions have already been taken and what more needs to be done in the coming year to mitigate the effects of the problem.

Table 2: Analysis of Issues and Actions to Reduce Project Impediment

The Issue	***What has been done***	***Further action/support needed***
Insecurity in St. Martin & Descayettes affecting level of activity on the ground.	Violence intervention program in St. Martin with support of Glencree Center for Reconciliation to conduct conflict mitigation between community and gang leaders and to protect the population. Concern is engaged in a coalition of international, national and metropolitan area organizations seeking strategies to mitigate violence and conducting advocacy with governmental and security sector authorities. Postponed nutrition survey until situation is safe in Descayettes. Concern is actively monitoring the security situation, providing training on security for staff safety, and abiding to area restrictions.	Patience and flexibility with implementation, identification of alternative health centers to serve affected populations during crises, continued work with national efforts and partnership with Glencree to continue conflict mitigation in St. Martin and to explore concrete conflict mitigation initiatives in the Descayettes area.
Community priority in water & sanitation (hardware)	Inventoried need in three neighbourhoods. Working to complete documentation and leverage financial support from alternative sources such as Concern's Urban Peace Building Project and other urban environmental health programs.	More communication with the Peace Building Project, fully document need and seek additional financial support with the local groups, raise outstanding issues to platform and include in advocacy (reference page 50 of the DIP).

The Issue	*What has been done*	*Further action/support needed*
Changes in MoH at national and West Department (DSO) level	There was significant involvement of former DSO in all stages of the DIP who has assigned a focal point, Dr. Gourdet who participated in Bangladesh exchange visit and first annual review and remains within the DSO. Since the DIP, the DSO has changed two times limiting progress in implementation as each time we need to re-establish our relationship and priorities despite the continued presence of our focal point.	Continue to make early introduction and orientation meetings with new persons in key MoH positions. Develop a MoU to improve continuity of relationship. Initiate the urban platform to strengthen operational links with MoH.
Youth leaders have unattainable expectations and selection done with limited resident's involvement	The staff have listened to needs and identified monthly meetings as a forum to provide desired skills and opportunities to youth. By design the scope of youth leaders' roles are limited to try to offset demands for compensation. We have identified the need to work with a younger youth age group that may not yet be forced to live independently and have fewer survival needs.	Develop a broader motivation strategy in conjunction with focus group discussions with adolescents; review experience with youth from other programs; Solicit support/engagement of other actors in vocational training/skill building opportunities for Youth Leaders. Ensure curriculum is acknowledged by the government and certify training.
Absence of key staff at Concern and GRET	Positions have been posted since May 2006 and several interviews were conducted; however, we have not yet found appropriate candidates. This is partially due to the security situation in Haiti as well as competition with bilateral health and HIV/AIDS programs. Provided additional support from US based staff and GRET Director.	Continue to prioritize recruitment; hire a consultant for six months to provide on the ground technical support in lieu of the Health Coordinator (contracted Isabelle Monroy in October 2006).
Challenges in communications and misunderstandings between implementing partners, health centers and CBOs	Agreed roles between actors and good participation of all stakeholders in DIP workshops. Initiated monthly team meetings since June 2006. Started discussions on performance incentives and community health planning with HC staff and CBOs.	Create space for exchange between HC and CBOs between neighbourhoods. Develop MoUs with HCs and possibly CBOs. Ensure all staff have strong understanding of vision and strategies through more orientation to program through regular meetings and strategy reviews.

C. Technical Assistance Needs

The following technical assistance needs were identified in the DIP and/or as part of the annual review by the project team. Plans to fill these needs are described in this section.

1. Behavior change strategy development. With national staff oriented on the BEHAVE framework, in April 2007 the Health Advisor will co-facilitate a workshop on the HIV/AIDS strategy using findings from the adolescent focus groups and existing secondary literature review to complete the first strategy. This process will continue for the other intervention areas every six months as designed in the DIP (see section H of this report).

2. Facilitation skills, circles of change – work with local organization specialized in open space and circles of dialogue methodologies to promote adult learning and participation of the population in behaviour change approaches. Skilled practitioners on the front lines of applying these methods in Haiti will collaborate with two project staff skilled in the methodology to train-up 24 facilitators from all five neighborhoods. They will be trained one day per week on basic skills from February – May 2007 and then apply approach for each of the technical modules related to maternal and child health.

3. Handwashing in urban slums. Due to lack of water supply and issues of security, we are challenged to look into alternative solutions to promote handwashing in most of the project area. The Health Advisor is communicating with the USAID funded Health Improvement Project (HIP) for guidance on this matter.

4. Nutrition in urban slums. Time and money are major impediments to child nutrition and feeding the sick child resulting in high levels of stunting and underweight children. A Concern Nutrition Advisor will complete a needs analysis and nutrition training with staff and partners and better inform the nutrition behavior change strategy. We are also looking into lessons learned from the IFPRI/WV nutrition work in Haiti. The nutrition advisor will also look into nutrition needs for PLWHA during her visit in early 2007.

5. Quality Assurance. An expert in developing quality assurance processes with teams is required to support the QA component of the program. We are seeking assistance from MSH and the local mission.

D. Project Monitoring System

Mme Hecdivert, the M&E Specialist on contract to the project all facilities in the project have been reviewed with the exception of Descayettes. This included the review of reporting formats, record keeping systems, transmission and use of reports, training in health management information system (HMIS), as well as specific information collected related to the project intervention areas. From this review, she recommended the use of the latest MoH reporting formats and trained Health Center Supervisors, Service Providers and Record Keepers for three days in June 2006.

During this period focus on establishing the system including a quarterly project reporting format to facilitate team analysis of the situation. A template was developed and the first report was completed for the period of July-September 2006. However, because many of the community and health facility reporting systems were not yet in place, routine data review was not included. A reporting format in excel has been developed to facilitate data entry from Health & Development Officer reports as well as Health Center data. It will facilitate data analysis by neighborhood, by month, quarter and project year.

Routine monitoring system from health centers will begin in October 2006 and a database has been designed to capture and facilitate analysis. Youth Leader and CBO reports are planned to start in 2007 depending on the situation in each of the neighborhoods.

E. Substantial Changes

No substantial changes in terms of objectives and indicators, interventions, specific activities, location, beneficiaries, local partner, or budget lines have been made since the approved DIP of June 30, 2006. However, some activities are running behind schedule due to insecurity and staffing shortages as described in section B.

We are carefully monitoring the security situation in Descayettes where life for the residents remains very stressful and intervention has been very difficult and dangerous. During the last four months of year one the neighbourhood was under a UN red alert and field staff were not permitted to enter the area. SNELAK was able to have some presence but the situation remains treacherous. Several potential community leaders have left the area due to threats, arson and kidnappings. Two staff from the SNELAK health center resigned and left Haiti. The project remains committed to working in this area and Concern is looking for ways to extend its conflict resolution and violence interventions to our partner, GRET to promote more stability in Descayettes. We will continue to communicate with our CTO and Mission counterparts to appraise the situation.

F. Sustainability Plan

The sustainability vision has already been articulated as the project's strategic objective:

> "Sustained Improvements in health status of mothers, children and youth in disadvantaged neighbourhoods"

The sustainability plan is informed by the Child Survival Sustainability Assessment Framework (CSSA) [see figure 1] which attempts to define the system and predict the likelihood of continued health benefits in the participating neighborhoods.

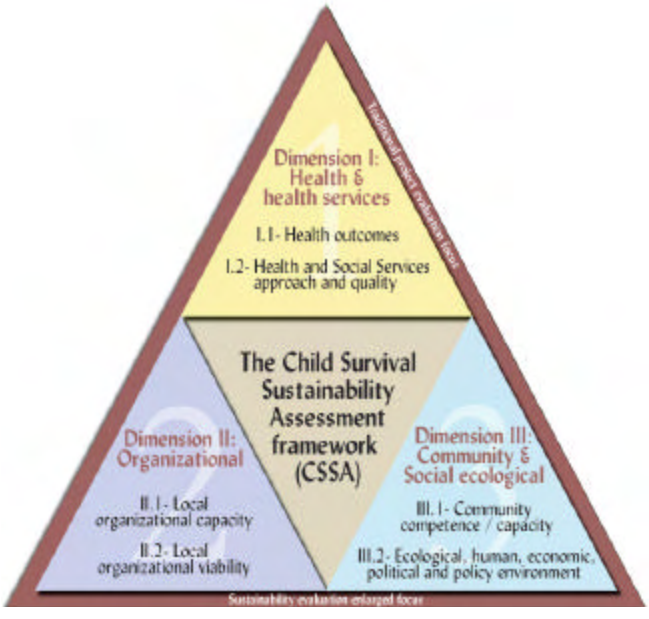

Figure 0: CSSA Framework

While the urban communities struggle with a fragile health system and general insecurity, the project is designed to build community ownership and capacity to promote health locally and influence urban health policy. Sustainability is not an end state in our definition but rather it's a paradigm for building interventions that should last with limited external facilitation in the future.

As part of the annual review, the team reviewed the definitions and measures for each of the essential dimensions and components. The most difficult part of this work was defining the institution that would continue to catalyze, lead the community health partnership at the end of the project. This was particularly hard due to the different contexts and levels of community based organization mobilization in each of the neighborhoods, with St. Martin being the most developed with an existing federation of CBOs while others are just beginning to come together. Political and social relations between these groups are often divisive, challenging the vision of encouraging them to unite for community health and development. Whether or not this structure is fully realized during the course of the project or simply steps are taking to encourage collaboration and resource mobilization for community health, the feeling of the team at this stage stands as a worthy vision to work towards while recognizing that it should not be forced as it may cause more harm than good.

The team will continue to carefully monitor the situation, particularly with the support of the Process Documentation and Research Resource Organization's quarterly community assessments, and review and rediscuss this each year to keep track of the appropriateness and feasibility of this strategy as the situation in the neighbourhoods evolves.

The following is an outline of the dimensions, components and assessment indicators developed to date. An excel sheet has been set-up to monitor and track this indicators. A first report on the system should be available for the second annual report when the community assessments are completed in year two.

Dimension I HEALTH GOALS

Component 1: Health Status (13 indicators, includes most of the rapid catch indicators)

- improved preventive child health practices
- improved care seeking for sick child
- improved MNC
- enhanced youth HIV/AIDS protection

Component 2: Quality health services: Enhanced availability, access and quality of health care

- number of services providing IMCI
- drop-out rate DPT3 – DPT1
- number of HCs deemed "youth friendly"
- number of services with formal referral mechanism with hospital
- number of TBA referrals
- number of health facilities with formal exemption scheme for poor

Dimension II ORGANIZATION GOALS

Component 3: organization capacity and component 4: viability

KDSM, SNELAK, Comite Pilot Cite Okay, and CBOs of Bois Moquette & Jalousie:

- **Analysis & Planning** (Awareness of local health problems, Creation of defined objectives and interventions to address problems, Development and execution of activity plans to address objectives)
- **Dialogue & Negotiation** (Identification of principle social actors and poles of interest, existence of a communication mechanism between actors, seek consensus between actors/social groups on common problems and objectives)
- **Structure & Organization** (Existence of organization structure representing different social groups, Representation of existing organizations, Internal structure of organization (roles & responsibilities, mgmt functions, Existence of initiatives and actions in response to known problems);
- **Links to health system** (Awareness of services offered at health institutions, communication with health workers [management and clinicians], Influence on attitudes and health care seeking strategies);
- **Resource mobilization** (Know resources available for health, Seek additional resources for health within the community, Seek additional resources outside the community)

Dimension III COMMUNITY GOALS

Component 5: Empowered communities with increased knowledge and interest in health

- Changes in community awareness of preventive and care-seeking practices
- Participation in the neighborhood's health planning and monitoring
- index of participation of in health promotion activities
- number of health meetings bringing together 3 or more CBOs in past month (depth)

Component 6: Socio-ecological environment

- household dietary index
- Violence/insecurity
- Natural disasters (floods, fires, hurricanes)
- Inflation/unemployment
- index of development of an urban health policy

G. Information specified in the DIP

As part of the DIP feedback, Concern was requested to respond to the following issues in its first annual report:

1. Review equity issues and indicators emerging from KPC. Several tools were used as part of the baseline studies to quantify areas and populations less served than others. These included the use of Lot Quality Assurance Sampling and Household Dietary Diversity Index (HDDI) which allow distinction of results across geographic neighbourhoods and three proxy wealth groups.

The HDDI was reviewed for 19 project specific and child survival rapid catch indicators comparing odds ratios of populations in the lowest wealth group to the highest wealth

group. While 12 of the 19 indicators had an odds ratio > 1 the indicators with highest gaps were:

The mothers of the highest wealth group were…

- 4. 88 times more likely to attend four or more antenatal care visits than the poorest group.
- 3.05 times more likely to receive full tetanus protection during last pregnancy than the poorest group.
- 2.43 times more likely to have been tested for HIV during last pregnancy than the poorest group.
- 1.93 times more likely to have a child fully vaccinated by the first birthday than the poorest group.
- 1.88 times more likely to have a newborn consultation within the first week of life than the poorest group
- 1.86 times more likely to have an accepting attitude towards persons living with HIV & AIDS than the poorest group
- 1.73 times more likely to purify their drinking water than the poorest group.

Interestingly, mothers in the poorest groups had a protective effect in terms of child spacing, knowledge of sick child danger signs and HIV preventive methods, seeking treatment for child with symptoms of pneumonia from a trained provider, and feeding and rehydrating the sick child.

A quick look through this indicates that Cite Okay is most consistently below the average and St. Martin not too far behind. Jalousie/Bois Moquette falls below for only one indicator - water treatment, which is interesting given all the effort FOCAS placed on this in their last CS program.

While there were only eight indicators out of 30+ that showed a statistically significant probability of being lower than the entire project area average, these consistently were Cite Okay/Jeremie and a couple of times also St. Martin. Further analysis is required once LQAS decision tables are available for denominators > 65. Table below highlights priority neighbourhoods and practices by intervention area:

Table 4: Lower performing baseline indicators by neighborhood

Neighborhood	Maternal & Newborn Care	Sick Child	Vaccinations	Nutrition
Cite Okay	Skilled delivery attendant at birth Newborn Care	Increased fluids/ maintained feeding	--	Exclusive breastfeeding
St. Martin	Newborn Care	--	Full vaccination by first birthday Maternal TT coverage (TT2+)	Vitamin A coverage children 6-11 months
Descayettes	--	--	--	--
Bois Moquette/ Jalousie	--	Water purification	---	--

A final version of the KPC Survey as well as supplemental analyses of the HDDI Odds Ratios and LQAS decision tables are available as annexes 2, 3 and 6.

2. Develop a communication strategy with the mission and bilaterals to work together to address performance incentives, IMCI strategy and newborns, involving with youth, and zinc and new ORS. There has been limited engagement with the MSPP after the DIP largely due to the absence of the Health Coordinator and pressing demands on the Project Manager to initiate programming in the five neighbourhoods. However, the project remains committed to playing a role in leadership in advancing these areas and harmonizing strategies.

3. Baseline assessment of underweight status of children under 23 months. As previously mentioned, we were unable to complete the survey due to security risks in Descayettes. However, the survey instrument has been designed and we expect to undertake the survey in early 2007. Note that the expected sample has been reduced to only assess levels of *moderate* acute malnutrition instead of severe as further analysis of the KPC 2006 survey indicated that this did not merit further investigation.

H. Behavior Change Strategy

The broad behaviour change goals and objectives and summary of the strategy are included in the DIP on pages 40-41 including a BEHAVE MATRIX highlighting This section explains what the situation is now and how we plan to operationalize the strategy.

The behaviour change strategy will be developed across **five topical themes** and sequenced about every six months. The first theme is HIV & AIDS and includes three practices related to youth delaying onset of sexual intercourse, using modern contraceptives, and using condoms as appropriate to age and personal situation. Ground research identifying facilitators and barriers of each behaviour have been identified as well as priorities for further formative research. This was reviewed as part of the annual review and included as Annex 4 to this report.

Led by the Health Officers with technical assistance from qualitative research expert, the formative research will be completed prior to BEHAVE workshops whose participants will consist of a expert working group of about 12 people comprising DSO/BC/MSPP, Health Providers, project staff, MSH, CBO members and other resource persons as needed. This team will analyze and group the research findings by determinants and collectively craft the key factors and activities to maximize efforts.

While strategies will be tuned to the findings and collective decisions of the expert group, some standard channels and media will be used across the board as follows:

1. Development of facilitators guide with stories around each of the key practices and storytelling pictures that they can use for learning circles of community dialogue and peer counseling

2. Orienting health facility staff on key messages and supporting actions that they can do to promote the behaviour followed by a quality assurance review related to the topic

3. Training of CBO & Youth Leaders by sub-zone by master facilitators on the materials and emphasis practices who in turn each organize 2-3 group events each with the facilitators to instigate community discovery with fathers and mothers.

4. Organizing community fairs and events that emphasize key practices with the CBOs

5. Where applicable, work with other USAID partners to expand to media channels such as radio and television

Monitoring of the strategy will be agreed by the expert group as part of the BEHAVE Matrix development where indicators for evaluating progress are established. Monitoring of the actual behaviour will be completed annually using LQAS and community assessments through focus group discussions with mothers and health providers.

Incremental progress monitors have been develop and outlined in detail in table 3 below. Following the theory of stages of change, the project staff and partners reviewed findings from the baseline studies (see annex) and debated where the majority of the women in their working areas were currently in the spectrum ranging from pre-contemplation to regular practice. The team found it most useful to work with four distinct classifications and then describe what they would see at each stage:

1. **Pre-awareness**: This refers to a population not yet aware of the need to practice particular health behaviour. They are lacking in both knowledge of the importance and benefit of the behaviour.
2. **Intention:** This refers to a population with a favourable attitude towards practicing the behaviour.
3. **Readiness**: This refers to a population that has the skills necessary to perform the behaviour and some experience trying it themselves. They may still be struggling with practicing it consistently but have a positive attitude towards taking the action.
4. **Maintenance**: This refers to a population where the majority are habitually practicing the healthy behaviour.

The shaded grey areas of table 3 on the next page signify the current situation for mothers in the neighbourhoods and what the principle issues appear to be. As outlined in the behaviour change strategy above, these categorizations will be reassessed following more formative participatory research with the women themselves with each of the phased interventions.

Table 3: Identification of Stages of Change for Priority Group Behaviors

Practice	**Pre-Awareness** Low Knowledge & Awareness	**Intention** Attitude	**Readiness** Skills & Trial	**Maintenance** Regular Practice
HIV & AIDS Practices				
Consistent use of condoms by youth aged 15-24 while with a non-union partner	Practical knowledge on how to use a condom Awareness on cost and location of condoms for youth to easily obtain	Perception that cost of condom is small compared to consequences of unplanned pregnancy, STIs, and HIV Reduced belief that condom use results in reduced virility Belief that it is respectable for young ladies to request using a condom to partner	Both men and women are comfortable talking about condom use with partner Young men are confident to wear a condom and how to dispose of it discretely	Youth increasing used condom during last sexual activity with a partner out of union.
Sexually active youth use modern contraceptive method	Awareness of at least two short term modern contraceptive methods Recognition that condoms protect from HIV as well as unwanted pregnancies Awareness of economic importance of delaying first pregnancy	Perception that a cool and wise youth protects self with modern contraceptive Youth feel welcomed and encouraged to participate in family planning services at the health centers Perception that modern contraceptives are safe and an expression of youth freedom rather than state oppression	Most female youth who are sexually active have identified a modern contraceptive method that suits their needs Most youth have visited the health center for family planning services and at least tried it once	Sexually active youth correctly and regularly use modern contraceptive method Health center staff welcome and encourage youth clients
Delay first sexual intercourse encounter of adolescents	Awareness of economic importance of delaying first pregnancy Awareness of personal risks of engaging in sexual relationship before ready	Female youth can identify at least three ways to earn cash in lieu sexual favours Youth recognize opportunity costs of raising a child	Increasingly female & male youth have made a deliberate plans to delay sexual activity	Both male and female youth delay on-set of sexual intercourse.
Sick Child Practices				
Families treat home drinking water with chlorine and store in proper storage container with narrow neck	Understanding of association between contaminated water and diarrhea Families know the cost, where to find, and how to treat and store water	The cost of treatment is perceived as cheaper than managing diarrhea Families know how efficacious water treatment is in purifying water Recognition that the changed taste means that the water is good Perception that good parents treat water to protect child because they are more vulnerable	Families have an appropriate container to store treated water in home Families reporting treating water when they can but may still have difficulty with cost of treatment	Most families with children under five systematically treat and store safe water in the home for consumption
Mother increasing fluids and maintaining frequent feeding of child with diarrhea	Recognition by mothers that child needs more fluids and continued feeding during diarrhea Mothers understand danger of dehydration of child with diarrhea and negative consequences of drying	Understanding that well hydrated child recovers better than a “dried” child Mother’s believe that active feeding of a sick child builds up appetite	Most mothers do attempt to increase fluids and maintain feeding of sick child. Mothers identify difficulties they have feeding and/or rehydrating child	Children with diarrhea are regularly receiving increased fluids and maintained feeding.

Practice	**Pre-Awareness** Low Knowledge & Awareness	**Intention** Attitude	**Readiness** Skills & Trial	**Maintenance** Regular Practice
Mothers of children with diarrhea correctly prepare and give ORS	Parents are aware of the need to provide ORS to child with diarrhea Mothers know where to find and how to prepare ORS	Belief that ORS is effective in managing rehydration Belief that child likes the taste of ORS Belief that time and cost of preparing ORS is small in comparison to consequences of a "dried" child	Mothers have given child with diarrhea ORS at least once in past year but still have some difficulty purchasing or preparing it.	Mothers routinely prepare and give ORS to child with diarrhea
Mothers promptly seeking care at the Health Center when child presents bloody diarrhea or persistent diarrhea of 14 days or more, or if acute watery diarrhea persists after ORS treatment	Parents know danger signs of diarrhea that needs medical attention. Parents know the cost of consultation at the health center	Belief that cost of and time to receive treatment at health center is cheaper and quicker than consulting the hospital later Recognition of blood or acute diarrhea or persistent diarrhea as a serious conditions and not normal diarrhea – need to treat differently	Parents have brought child with danger signs of diarrhea requiring medical assistance Increased use of OPD services at health center for diarrhea	Parents routinely bring child with diarrhea danger signs to the health center
Mothers promptly identify danger signs of the newborn and child and promptly seek care at the Health Center	Mothers recognize key newborn danger signs Mothers know what problems should be seen at the hospital and which are okay to be seen at the health center or by a TBA	Belief that families should act quickly to take child to hospital if danger sign present Perception that health staff can effectively help newborns with medical problems Belief that costs of medical services will not be insurmountable	Some examples of families who experienced newborn complications who transferred baby to the health center or hospital are known within the neighbourhood	Several examples exist in all neighborhoods of families who experienced recent newborn complications who sought care at hospital or health center.
<u>Health providers</u> effectively assess, classify, treat and counsel mothers **(Note change in priority group)**	Doctors and nurses at the health centers recently trained in IMCI protocols Job aides available at health center on IMCI protocols in appropriate locations (consultation rooms and pharmacy)	Doctors and nurses believe that protocols improves their performance/efficacious Doctors and nurses believe that the protocols make their work easier. Doctors and nurses are confident that prescribed treatment is always available in the pharmacy Health center staff believe that their supervisor cares about application of IMCI protocols	Doctors and nurses make an effort to systematically use protocols and can identify areas where they are having difficulty (time, drugs, mothers understanding)	Doctors and nurses screen children for danger signs and can clearly show in case notes how classification was done. They make an effort to ensure counselng well done and understood by mother.
Mothers provide full treatment of antibiotics and increased fluids and	Parents understand why child must complete antibiotics even when symptoms are alleviated	Diminish perception that antibiotics should be shared with all children in household to prevent illness	Mothers can show antibiotic package and explain how given to child since diagnosed.	Mothers provide full course of antibiotics even if child is feeling better and

Practice	**Pre-Awareness** Low Knowledge & Awareness	**Intention** Attitude	**Readiness** Skills & Trial	**Maintenance** Regular Practice
maintain feedings for sick child with pneumonia	Parents understand importance of feeding sick child as well as providing medicine Parents know the cost and where to receive inexpensive course of cotrimoxazole (1st line) or amoxicillin (2nd line)	Willingness to pay for and administer full course of antibiotics to child even though symptoms may alleviate much sooner Belief that essential and cheaper antibiotics work just as well as more expensive ones from pharmacies	Most mothers do attempt to increase fluids and maintain feeding of sick child. Mothers identify difficulties they have feeding and/or rehydrating child	improve feeding of the sick child
Nutrition Practices				
Mother frequently and exclusively feeds infant under six month breast milk	Women know importance of feeding colostrums to newborn Families understand how frequent feeding increases supply of breast milk Families understand the benefits of exclusive breastfeeding	Mothers believe that frequent lactation increases supply, even for a women who's food intake is minimal Mothers perceive the opportunity cost of exclusive breastfeeding as most important investment of time and energy	Mothers intend to breastfeed exclusively to six months at time of delivery Mothers seek breastfeeding advice from health providers when facing difficulty.	Mothers exclusively breastfeed child to six months and seek advice when having problems.
Mother provides at least 3 complementary feeds plus breastmilk for infant 6-9 months	Families know that the child needs 3 meals plus snacks at this age to maintain adequate growth Mothers know practical ways to provide additional meal to child (family eats 2x day)	Families give priority to feed child frequent meals and snacks because know investing in its future Mothers believe they can find low cost ways and time saving ways to provide an additional meal for complementary feeding Mothers believe that they must continue to breastfeed beyond six months even though it takes time and energy	Mothers have practical ways to increase to 3 meal feeding for infant at this age. They try to do it but have times when it is not possible.	Mothers find practical ways they can maintain to provide 3 daily meals plus breastfeeding
Mothers store complementary foods for child in clean and covered containers and cooked with boiled or treated water (for water treatment – see diarrhea)	Food hygiene is known by mothers Mothers know practical ways to safely store food with low cost materials	Families believe they can find low cost food storage materials Mothers prioritize food hygiene in their homes	Parents make an effort to safely store clean and covered food in the home. They can clearly identify challenges and try to find solutions.	Children's food is safely stored in most homes in the most disadvantaged areas.
Mother seeks Vitamin A supplementation every six months for child 6 to 59 months	Families know value of Vitamin A in protecting child health Mothers know frequency of Vitamin A schedule and where and how to get it for free	Mothers are confident that they can get Vitamin A free of charge at the health center whenever they go Mothers view Vitamin A supplementation as one of the best free things they can do for their child	Most children receive Vitamin A supplementation however some mothers experience difficulty obtaining it.	Most children supplemented with Vitamin A in past 6 months in all neighborhoods

Practice	**Pre-Awareness** Low Knowledge & Awareness	**Intention** Attitude	**Readiness** Skills & Trial	**Maintenance** Regular Practice
Vaccination Practices				
***Health providers** screen vaccination status of all children and administer vaccine	Providers know that checking vaccination status is part of government protocol Providers know that catching missed opportunities will help them achieve higher vaccination coverage Providers know that their bosses want a high vaccination coverage for their working area	Providers believe that it is safe to vaccinate a sick child Providers perceive that checking the vaccination is a routine part of any child consultation Providers confident that vaccines are available so child referred will receive them Providers trust vaccination cards are correct and up-to-date	Providers routinely check vaccination status but identify barriers to identifying and/or vaccinating missed opportunities	Providers routinely check vaccination status of children and can easily cite missed opportunities that they successfully identified and got caught up on vaccination schedule.
Mothers of children under-one bring child to health facility every month for first 3 months and before 1st birthday for the purpose of vaccinations	Family knows the importance of preventing diseases with vaccinations and that they are free of charge. Family knows they are responsible to bring child in for vaccinations monthly for first 3 months and again before first birthday. Family knows vaccines not complete until child receives measles vaccine before 1st birthday	Mothers understand that common side effects are due to vaccines but they are minor compared to the risk of disease Mothers trust health providers to fully and safely vaccinate child Families recognize that it is their responsibility to take the child to the health center for vaccines even though it takes time	Mothers take child to the health center and retain record of vaccines. They may have some trouble keeping up with the schedule and can rationalize these barriers. Minimal to no vaccine preventable disease outbreaks in neighbourhood.	Nearly all children are fully vaccinated before 1st birthday and have a record of it. Minimal to no vaccine preventable disease outbreaks in neighbourhood.
***Health providers** proactively seek tetanus toxoid protection for women of childbearing age	Providers know that checking vaccination status is part of government protocol Providers know that catching missed opportunities will help them achieve higher vaccination coverage Providers know that their bosses want a high vaccination coverage for their working area	Providers trust that mothers will accurately tell them their TT status even if card is not available Providers confident that can use vial if opened and that their supervisor will support them if some vaccine has to be thrown out	Providers routinely ask about TT status of pregnant mothers and try to provide vaccine at every consultation as required but have some problems they can clearly explain. Notes of situation are written on all mothers cards.	Providers routinely seek to know TT status of pregnant mothers and provide vaccine during consultation as required. Notes of situation are written on all mothers cards.
Families recognize danger signs of pregnancy, postpartum and newborn and go straight to the	Families of expecting mothers are aware of several emergency danger signs during pregnancy, labour and postpartum period Families know where they can receive	Families believe that the earlier they bring in a woman with complications, the less expensive it will be and the more likely both mother and baby will survive	Some examples are known locally of mothers with complications who were referred to the hospital.	Recent examples are known locally of mothers from the neighbourhood who were referred to the

Practice	**Pre-Awareness** Low Knowledge & Awareness	**Intention** Attitude	**Readiness** Skills & Trial	**Maintenance** Regular Practice
hospital	emergency obstetric care and how to get there	Families believe that whatever the costs they can work out reasonable payments with the hospital		hospital due to complications during labor and postpartum.
Mothers purchase and use a clean delivery kit	Expecting mothers of all ages know tools needed for a basic clean delivery Mothers know where and how much to pay for basic supplies (soap, razor, cord tie, gloves)	Mothers believe that materials for a clean delivery are accessible and worthwhile Families desire to have all materials ready for a clean and safe delivery	Most mothers know what materials are needed and have made a genuine effort to procure them.	Most mothers procure essential materials for a clean delivery.
TBAs and Auxillary Nurses conduct postpartum visits in mother's homes within 48 hours of delivery[1]	TBAs and Auxillary Nurses know what they should check and when during postpartum visit. TBAs and Auxillary Nurses know when and why 60% of mothers die due to maternal complications.	TBAs & Auxillary nurses believe they can detect and confidently refer postpartum complications TBAs & Auxillary nurses are confident that the hospital will quickly provide efficacious care to cases they refer	Some real life examples of women with postpartum complications identified by TBAs and/or Auxillary Nurses are known.	Recent examples of real life examples of women from each neighbourhood with postpartum complications identified by TBAs and/or Auxillary Nurses are known.

[1] Behavior modified to reflect correction in national policy interpretation which permits postpartum consultations by trained TBAs and auxillary workers.

L. MANAGEMENT SYSTEM

Table 5: Summary of Management & Team Building Activities

Major Activities	COMMENTS *(facilitating and impeding factors, areas where need assistance, things that need to be discussed changed)*	Implications for next year's work
Project Management Meetings (quarterly)	Absence of CW Health Coordinator and GRET Project Manager over past 6 months resulting in management meeting vacuum.	Each agency to designate senior staff to act in managers absence. Continue to prioritize replacement of vacant positions.
Project Annual Review & Report	Data from Health Centers not used as compilation system still under development.	Improve process including use of monitoring data and participation of HC staff, CBOs, and MSPP
Recruit and orient additional staff	Recruited Health Services Capacity Building Officer, Three Health Officers, and One Liaison Officer. Remaining vacancies include Project Support Officer as reassessing the need for this position.	Reassess need for Project Support Officer and take necessary action. Still need Health Coordinator & GRET Project Manager
Initiate Monthly Team Meetings	Team has held 3 monthly meetings but problems with reporting by individual partners so need to clarify reporting requirements and communication lines.	Ensure clear expectations for monthly reporting and format. Review inter-organizational reporting lines for monthly reports.
Exchange visit to Bangladesh on C-IMCI and Community Mobilization	Four staff participated in May 2006 and the focal point from the DSO. Excellent lessons in working with local government with community groups.	Continued exploration of opportunities to engage local leaders in health promotion / advocacy.
DIP feedback and negotiation w/USAID	Completed DIP submitted on June 30, 2006 and disseminated to national partners and posted on DEC. In process of translating key sections.	Complete translation of abbreviated DIP for dissemination and use.
QA training with Concern HIV team	HIV team had too many ongoing activities to do new grants and postponed until February 2007. Team considering contracting technical support to work with committee to develop training package for project and conduct initial training.	Ensure developing QA training package and training capacity in place for roll-out to health centers.

Financial Management system:

Basic systems in terms of finance and administration guidelines are in place and implementation monitored in the Country Office and with the subgrantee partners – GRET and FOCAS. Quarterly financial reports are submitted to Dublin and New York and reviewed at the Quarterly Management Meetings in Port au Prince with all three agencies. In September 2006 all three partners, Concern Worldwide Haiti, GRET and FOCAS and both were very satisfied with the financing system to date.

Concern Worldwide US submits quarterly financial reports to USAID/W as required under this agreement. Generally, expenditures are on track as per budget.

Human Resources:

At the time of the annual review, all full-time project positions had been filled consistently since May 2006 and the team has started monthly meetings. There are some issues building a team when Officers of the partner organizations do not report directly to the Project Manager but with time these issues are being identified and worked on with respective managers. One position, the Project Support Officer, has not yet been recruited for as the scope of this position is still be defined.

Vacancies at the Management level has been an issue over the past six months in terms of the Health Coordinator (40% to project) position at Concern and the Project Manager Position at GRET (50% to project). Refer to section B for further details on actions taken and plans to move forward.

Communication system, team development and Local Partner Relationships:

While there has been excellent participation in the DIP development and annual review and planning, communications, team development and local partnerships are all at an early stage in the project. This is an area that is just getting started and identified by most of the staff and partners as a critical area for year two. It is not uncommon for their to be misperceptions about the project, its strategies and parameters of what it does and does not do in the start up phase of a Child Survival Project. In fact, Concern Worldwide consistently has identified this as a major issue in its first annual reports.

Work in year two will focus on clarity of objectives and parameters among the project staff and with stakeholders, negotiation and writing of MoUs with the DSO, Health Centers and if appropriate CBOs. More attention needs to be given to dialogue between health center staff and CBOs as there is a perception that the health facility support will be abandoned in favour of community mobilization. Joint work, MoUs and action should calm these fears.

Concern, FOCAS and GRET are still working out the details of the performance incentives. Time must be invested to develop common performance areas, targets and agreed upon bonus parameters.

PVO Coordination / collaboration

There has been some collaboration with AMESADA and this project in the development of the DIPs and again at the Fall CORE meeting in DC. However, engagement with the Haitian Health Foundation and Global Health Action has been less as they are one year ahead in their implementation cycle and work far away from the metropolitan area.

We would like to encourage AMESADA's participation in the urban platform as they work in the peri-urban area and fall under the jurisdiction of the MoH West Department. A suggestion would be for USAID to convene all four CS implementers in Haiti to share achievements and identify common constraints and possible solutions with UNICEF, USAID and the MoH prior to the end of the year as all projects have been constrained due to insecurity and lack of essential meds and supplies over the past year.

M. MISSION COLLABORATION

Concern Worldwide has had regular contact with Dr. Desinor at the USAID mission in all phases of preparing the DIP as well as working out operational issues with other USAID funded actors working in Port-au-Prince.

In year two, we will work with the mission to find opportunities for more child survival focused meetings to share successes, issues and identified common opportunities and solutions. See the last paragraph of the above section. We will also explore collaboration with the team working with youth.

N. TIMELINE FOR YEAR TWO

While the project is making progress we have decided to slow down the roll-out of the following planned activities due to factors identified early in this report:

1.Roll-out of youth leaders selection and training start in one neighbourhood before expansion as need to better develop approach, ensure that using the best selection criteria and mobilizing support from other actors interested in working with youth

2. Postponing initiation of maternal and newborn care strategy and mobilization due to load of activities

3. Carrying over nutrition survey due to insecurity in Descayettes during year one – code red from March – September 2006

Further, we are building on learning from the Bangladesh Exchange visit to seek ways to engage the local authorities who have responsibilities for waste management systems in the neighborhoods. The project team will facilitate meetings between the communities and local authorities who will be newly elected in December, to discuss possible ways of collaboration on this issue as a starting point..

O. RESULTS HIGHLIGHTS

Conducting the KPC surveys in the disadvantaged neighbourhoods participating in the urban health project was very challenging yet revealed compelling data about not only the masking of the health situation of these urban neighbourhoods but also facilitated the involvement and collaborative learning between the project and local stakeholders. In fact staff preclude that without their involvement, access to these neighbourhoods would not have been possible due to the high level of insecurity. Local communality know how was key to access.

Figure 1: Cite Okay

Conducting the survey helped the local team to gain insight about community lifestyle and the health environment. Normally this community is not very willing to be interviewed due to a high level of frustration with previous promises that they felt unfulfilled. The availability of CBO members to accompany survey team and spend time was important. Further the ability of the team to be agile to uprisings yet be engaged in the

community was key. Finally, in addition to unmasking disparities, the CBO members felt like they were truly change agents for health because of the role they played in the survey.

The table below compares the some of the survey results for the project area to the preliminary DHS 2005 report for the metropolitan area.

TABLE 6: Comparison of health indicators from 2006 project area survey and the 2005 DHS Preliminary Results, in percentage

Health Indicator	KPC 2006	Preliminary 2005 DHS Results for Metropolitan Area
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	28 (CI 20-38%)	40.7 (National)
Proportion of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	52 (CI 40-64%)	87.4 (National)
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	50 (CI 42-57%)	52.8
Proportion of children age 0–11 months whose births were attended by skilled health personnel	44 (CI 37-50%)	48.1
Proportion of children age 12–23 months who received a measles vaccine	61 (CI 51-71%)	59.8

While the infant and child feeding practices are markedly worse than overall national DHS findings, the results do indicate that the situation is slightly under performing compared to the metropolitan average for skilled attendant at delivery and provision of ORS to sick children with diarrhea, confirming issues raised in the DIP regarding reduced access to maternity services and socially marketable products. The coverage of measles vaccine was just about the same as the overall metropolitan area average.

[i] Country Profiles from Population and Reproductive Health. Policy Reports and Indicators 2005 – Joint UNFPA/Population Reference Bureau Publication.

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2														Responsible	Comments
						1st Qtr	2006 Oct	2006 Nov	2006 Dec	2nd Qtr	2007 Jan	2007 Feb	2007 Mar	3rd Qtr	2007 Apr	2007 May	2007 June	4th Qtr	2007 July	2007 Aug	2007 Sept		
	IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion																				
	IR 1A: Behavior Change Strategies at Platform Level (Elaboration des strategies)																				
1	Develop BEHAVE strategy for safer sexual practices among youth and pregnancy prevention			New	Need to complete adolescent focus groups in neighborhoods prior to BEHAVE development									X	X						CW Health Advisor	BEHAVE training in Mali Jan 2007
2	Adapt and develop BCC materials for HIV			New	Some materials available from FONKOZE reproductive health adult learning approach					X	X	X	X	X	X	X	X				FOCAS	Fonkoze RH materials to be reviewed
3	Develop MNC BEHAVE strategy for: Postpartum visit in 7 days; delivering at Hospital in face of danger signs			New		Moved to Year Three																Moved to year 3
4	Adapt and develop BCC materials for MNC			New		Moved to Year Three														X		Moved to year 3
	IR 1B: Community Mobilization																				
	Establish Youth Leader Model in Cite Okay																				
	Complete selection of youth leaders in Cite Okay						X	X	X		X	X									Project manager with Health officer	Support from CD needed on targetting adolescents
8	Orientation of Youth Leaders to their roles	X	X	On Track	Training curriculum of 12 modules should be reviewed and endorsed by MSPP so that it is recognized and participants receive certificates.		Module review	X	X		Youth orientation	X	X								project manager	
5	Youth Leaders report on births, deaths, and reportable diseases monthly to the health center			new						X		X	X	X	X	X	X	X	X	X	Health Officers	
6	Hold monthly meetings with Youth Leaders incorporating life and business skills for their development and motivation			New	Urgently need a motivation strategy and need to look at how other agencies interested in HIV and youth can further support them to make the monthly meetings useful (vocational education, microfinance, culture/art, etc) and not just about health.							X	X	X	X	X	X	X	X	X	Health Officers	
	Scale Up Youth Leader model in remaining neighborhoods																				

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2															Responsible	Comments
						1st Qtr	2006 Oct	2006 Nov	2006 Dec	2nd Qtr	2007 Jan	2007 Feb	2007 Mar	3rd Qtr	2007 Apr	2007 May	2007 June	4th Qtr	2007 July	2007 Aug	2007 Sept		
	Selection of youth leaders based on learning from Cite Okay in Descayettes, St. Martin, Bois Moquette & Jalousie														X	X	X					
8	Orientation for Youth Leaders in remaining neighborhoods	X	X	New		X				X									X	X	X	
7	CBO & Youth Leaders organize community dialogue on HIV transmission, prevention, misinformation, VCT/PMTCT serivces, and stigma			New									x					X				
	IR 1.3 Developing Cadre of Health Education Faciltiators																					
9	Selection of Community health education Facilitators (24)		X	attention	Complete selection, orientation and facilitation training.				X		X											
	Training Facilitators in Adult learning & Circles of Change			Added								X	X		X	X						
#	Training of CBO and Youth Leaders on "Facing AIDS Together"			new												X	X					
#	Training of CBO & Youth Leaders on community mobilization for maternal and newborn care			new		Moved to Year Three																Moved to Year 3
	IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas																					
#	Confirmation and social marketing orientation for condom distributers targeting youth aged 15-30 years	X	X	On track	Need to follow-up with vendor orientation plan and contact PSI regarding institutional support with training and procurement.	X	X	X	X												Project Manager with Health Officers	
#	Water and Sanitation Committees conduct situation analysis on opportunities for public hand washing stations and distribution points for ORS and Chlorine treatment		X	Attention	Write up findings for proposal for areas that cannot be supported by Concern's Urban Violence program in St. Martin & Cite Okay Continue discussions and promote opportunities to put strategies in place. Mapping should be documented.	X	X	X	X				X								Officers (Dev & Health)	Expert handwashing engineer for urban environments sollicited

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2															Responsible	Comments
						1st Qtr	2006 Oct	2006 Nov	2006 Dec	2nd Qtr	2007 Jan	2007 Feb	2007 Mar	3rd Qtr	2007 Apr	2007 May	2007 June	4th Qtr	2007 July	2007 Aug	2007 Sept		
#	Training on Essential Drugs Management		X	In Process	Follow progress on update of Rationalization of Drugs module										X							Health Services Capacity Building Officer	
#	Capitalization of essential drugs for health centers		X	In Process and Attention						X								X				Health Services Capacity Building Officer	
#	HC personnel deliver information on maternal health and HIV/AIDS			new						X		X	X	X	X	X	X	X	X	X	X		
#	Reorganization of Vaccination register by Sub-zones to facilitate tracking with CBO & Youth Leaders			new											X	X	X	X	X	X	X	Dev Officer M&E Advisor	Qtr 3 org of zones Qtr 4 registers
	IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers																						
#	Training health workers in St. Martin & Cite Okay on IMCI			attention	Reassess opportunity to complete IMCI training in 2007	X		X														Health Services Capacity Building Officer	
#	Training of Quality Assurance Facilitators		X	attention	Ensure developing QA training package and training capacity in place for roll-out to health centers.	X						X										Health Services Capacity Building Officer	Require consultant to lead the training/ check with USAID
#	IMCI quarterly joint supervision to Descayettes, Cite Okay & St Martin			new						X				X				X					
#	Health facility staff deliver quality maternal and newborn care dialogues to groups waiting for care			new						X	X			X	X			X	X			Health Services Capacity Building Officer	With DSO IMCI Trainers
#	Training of health center staff on adult learning and nutrition			new														X		X		Health Services Capacity Building Officer	
#	HC staff deliver quality information on growth monitoring and nutrtion counsellng			new							X	X	X		X	X	X	X	X	X	X	Health Services Capacity Building Officer	
#	Quality assurance teams analyse promotion of IMCI counseling and hygiene promotion			new									X	X	X	X						Health Services Capacity Building Officer	
#	Refresher training on pre and post natal care for health service providers			new		Moved to Year Three																	

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2 1st Qtr	Oct	Nov	Dec	2nd Qtr	Jan	Feb	Mar	3rd Qtr	Apr	May	June	4th Qtr	July	Aug	Sept	Responsible	Comments
#	Quality assurance team analysis and address ANC services integration and education			new		Moved to Year Three																	
	IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.																						
#	SEMIANNUAL Urban Platform meetings	X	X	Attention	Request support from CW & GRET Directors to organize introductory meeting, sharing DIP and working together on letter of agreement including clarifying role in platform. Aim for first meeting by Jan 07					X	X			X				X	X			Project Manager	
#	Contribute to revision of the national TBA curriculum with MSPP, MSH, UNICEF, and other CS grantees	X	X	Attention	Follow-up with MSPP and UNICEF for further informaton about status on how to get involved in the review	X			X	X			X				X				X	Health Coordinator (vacant)	
add	Mapping health partners w/bureaux communales in Cite Oaky	X	X	In process	Priority is mapping for Cite Okay			X	X													Project Manager	With DSO/BC/HaitiMed & Food for Hungry
#	Collaborate with DSO in annual urban health planning and review through the Platform			new														X	X	X	X	Health Coordinator (vacant)	
#	Establish regular links with UNICEF, WHO, UNFPA to ensure coordination of programs and subsidized services			new		X	X	X	X													Health Coordinator (vacant)	
#	HC orientation visits to Jude Anne and LHUEH and develop patient information package for referrals			new		X		X														Health Services CB Officer with PM	
#	Engage with MSPP in the development of the national C-IMCI strategy with particular accent on malnutrition			new										X			X	X			X	Health Coordinator (vacant)	
#	Quarterly review of HMIS system at DSO, BC and neighborhood level			new						X		X		X		X		X		X		M&E Advisor	
#	Nutrition, Livelihoods & Willingness to Pay Survey in 3 Neighborhoods	X	X	Attention	Seek support from CW US Health Advisor to work with contractor on protocol and complete survey by early 2007, pending improved security in Descayettes.						X											CW US Health Advisor with Health Coordinator	

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2 1st Qtr	2006 Oct	2006 Nov	2006 Dec	2nd Qtr	2007 Jan	2007 Feb	2007 Mar	3rd Qtr	2007 Apr	2007 May	2007 June	4th Qtr	2007 July	2007 Aug	2007 Sept	Responsible	Comments
#	Host nationl reflection on management of severe malnutrition and orientation to community based therapeutic care approach			new														X			X	CW US Health Advisor with Health Coordinator	Need technical support from Nutrition Unit
	Special Studies/Tools																						
	Adolescent focus group studies on attitudes and practices										X											Process Documentation Consulting firm with Health Coordinator	
added	Dissemination of KPC Survey	X	X	Done	Hold national meeting to disseminate survey report. Share meetings at community health forum for feedback as part of annual planning.		X	X	X													Health Manager & ACD Programme	
#	Feasibility review of local production of ready to use therapeutic/supplementary food with CW/US support			new						X	X	X	X									CW US Health Advisor with Health Coordinator	
#	Process documentation organization complete assessments in five neighborhoods (suggested order: Cite Okay, Bois Moquette, Jalousie, Descayettes, St. Martin)		X	On track	Need further input from community on the indicators and targets; Will need to complete the asessments in five neighborhoods in next year as baseline.				X			X			X		X			X		Process Documentation Consulting firm with Health Coordinator	
#	Establish criteria for "Youth Friendly Health Centers" and integrate into MNC supervision tools			new		Moved to Year Three																	
	MANAGEMENT																						
#	Complete letters of understanding with roles and performance incentives guidelines with Health Centers and DSO		X	attention	Model letters to be developed including clause that work amitably on performance incentives approah so that is no further delayed. Should also consider letters for CBOs where appropriate like KDSM, SNELAK…		X	X	X													Health Manager w/Health Advisor	
#	Establish agreements and guidelines for performance incentives with 5 health facilities	X	X	attention	Group to review criteria used in FOCAS areas to collaboratively develop exceptional performance recognition standards; Concern needs to reassess incentives approach to ensure that it will do more good than harm. A day of dialogue among CW/GRET/FOCAS is required as well as a firm decision day with appropriate managers.		X	X	X		X	X	X									Health Coord w/ACD Programme	FOCAS & CW to Share plans, group to agree on criteria

	Major Activities	2006 Apr-Jun	2006 Jul-Sept	STATUS	COMMENTS FROM YEAR ONE	Year 2 1st Qtr	2006 Oct	2006 Nov	2006 Dec	2nd Qtr	2007 Jan	2007 Feb	2007 Mar	3rd Qtr	2007 Apr	2007 May	2007 June	4th Qtr	2007 July	2007 Aug	2007 Sept	Responsible	Comments
#	Monitoring & management of performance incentives and quality assurance			new										X	X	X	X	X	X	X	X	Health Services Capacity Building officer	
#	HC Staff conduct annual review and workplan development based on Health Facility & Community Information			new		X	X	X	X													Health Services Capacity Building officer	
#	Develop relationships and linkages with UNFPA/UNICEF/ LHUEH / Jude Anne and MSF/H for coordination of maternal & newborn care			new	Request support from CW & GRET Directors to follow-up with MSF/Holland to have a clear referral relationship for underserved neighborhoods.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Health Services Capacity Building officer	
#	Refine HFA tool to ensure inclusion norms of MSPP 1st Level Health Center and complete assessments			new						X	X	X	X									Process Documentation Consulting firm with Health Coordinator	
#	Project Management Meetings	X	X	Attention	Each agency to designate senior staff to act in managers absence. Continue to prioritize replacement of vacant positions.						X								X			Health Coordinator (vacant)	
#	Project Annual Review & Report		X	Done	Improve process including use of monitoring data and particpation of HC staff, CBOs, and MSPP													X			X	Health Coordinator (vacant)	
Added	Recruit and orient additional staff	X		In process	Reassess need for Project Support Officer and take necessary action. Still need Health Coordinator & GRET Project Manager		X	X	X													Project Manager / CD/ GRET	
Added	Strengthen monthly team meetings	X	X	In process	Ensure clear expectations for monthly reporting and format. Review inter-organizational reporting lines for monthly reports.		X	X	X		X	X	X		X	X	X		X	X	X	Project Manager	

ANNEX 2: HDDS Equity Analysis

Indicator	Indicator value						Odds ratio of Group 3 to Group 1		
	HDDS Group 1 (lowest)		HDDS Group 2		HDDS Group 3 (highest)				
	Num	Denom.	Num	Denom.	Num	Denom.	Odds ratio[@]	Lower confidence limit for odds ratio[&]	Upper confidence limit for odds ratio[&]
PROJECT INDICATORS									
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	25	71	28	70	61	84	4.88	2.46	9.67
Proportion of mothers of children age 0–11 months whose last delivery was attended by a traditional birth attendant	34	71	28	70	43	84	1.14	0.61	2.15
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	18	71	21	70	38	84	2.43	1.22	4.83
Proportion of mothers of children age 12–23 months who demonstrate an accepting attitude toward people living with HIV/AIDS	3	43	4	57	6	49	1.86	0.44	7.94
Proportion of mothers of children age 12–23 months who purify drinking water	13	43	14	57	21	49	1.73	0.73	4.10
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	27	53	21	58	44	74	1.41	0.69	2.88
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	31	43	34	57	36	49	1.07	0.43	2.69
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	12	17	18	29	20	31	0.76	0.21	2.72

Indicator	Indicator value						Odds ratio of Group 3 to Group 1		
	HDDS Group 1 (lowest)		HDDS Group 2		HDDS Group 3 (highest)				
	Num	Denom.	Num	Denom.	Num	Denom.	Odds ratio[@]	Lower confidence limit for odds ratio[&]	Upper confidence limit for odds ratio[&]
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	3	17	0	29	5	31	0.90	0.19	4.32
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	9	71	9	70	18	84	1.88	0.79	4.49
RAPID CATCH INDICATORS									
Proportion of children age 0–23 months who were born at least 24 months after the previous surviving child	20	28	25	32	29	47	0.64	0.23	1.77
Proportion of children age 0–11 months whose births were attended by skilled health personnel	27	71	33	70	37	84	1.28	0.67	2.44
Proportion of mothers with children age 0–11 months who received at least two tetanus toxoid injections before the birth of their youngest child	7	71	15	70	21	84	3.05	1.21	7.67
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	11	29	20	35	20	37	1.93	0.72	5.18
Proportion of children age 12–23 months who received a measles vaccine	16	29	22	35	24	37	1.50	0.55	4.06
Mothers with children age 12–23 months who cite at least two known ways of reducing the risk of HIV infection	40	43	50	57	43	49	0.54	0.13	2.29

Indicator	Indicator value						Odds ratio of Group 3 to Group 1		
	HDDS Group 1 (lowest)		HDDS Group 2		HDDS Group 3 (highest)				
	Num	Denom.	Num	Denom.	Num	Denom.	Odds ratio[@]	Lower confidence limit for odds ratio[&]	Upper confidence limit for odds ratio[&]
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	1	43	2	57	1	49	0.88	0.05	14.43
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	18	43	15	57	14	49	0.56	0.23	1.32
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	14	87	7	101	16	109	0.90	0.41	1.96

Notes

@ The odds of appropriate knowledge, practice, or coverage in the highest group relative to the lowest group.

ANNEX 3: Equaty Analysis Calculations - LQAS

Indicator Definition	Number Correct: Jalouzi/Bois	Number Correct: Mdet	Number Correct: Cite Okay/	Number Correct: Jeremie	Number Correct: St. Martin	Number Correct: Descayettes	Number Correct: Total	Denominators: Jalouzi/Bois	Denominators: Mdet	Denominators: Cite Okay/Jeremie	Denominators: St. Martin	Denominators: Descayettes	Denominators: Total	Overall Coverage
Proportion of mothers of children age 0–11 months who had four or more antenatal care visits during their last pregnancy	26	21	26	44	**117**	54	48	55	69	**226**	**52%**			
	20	19	21	n/a										
Proportion of children age 0–11 months whose births were attended by skilled health personnel	17	11	32	33	**93**	54	48	53	69	**224**	**42%**			
	15	14	15	17										
Proportion of mothers of children age 0–11 months whose last delivery was attended by a (trained and untrained) traditional birth attendant	33	33	14	33	**113**	54	48	55	69	**226**	**50%**			
	19	17	19	n/a										
Proportion of mothers of children age 0–11 months whose last delivery was at a hospital	12	10	31	28	**81**	54	48	55	69	**226**	**36%**			
	13	11	13	n/a										
Proportion of mothers of children age 0–11 months who received no iron and folate supplement in last pregnancy	26	16	23	22	**87**	54	48	55	69	**226**	**38%**			
	13	11	13	n/a										
Proportion of newborns who received care in the first week of life by a skilled healthcare provider (Denominator: mothers of children age 0-11 months)	10	6	9	17	**42**	54	48	14	22	**138**	**30%**			
	9	8	10	n/a										
Proportion of children age 0–23 months who were born at least 24 months after the previous surviving child (Denominator: Children age 0-23 months	21	13	20	28	**82**	30	23	27	29	**109**	**75%**			
	20	16	18	20										
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	14	13	18	33	**78**	54	48	55	69	**226**	**35%**			
	9	8	10	3										
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	11	5	5	3	**24**	24	14	20	5	**63**	**38%**			
	6	4	5	n/a										
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	4	4	6	1	**15**	24	14	20	5	**63**	**24%**			
	2	1	2	n/a										
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	14	14	10	13	**51**	41	47	37	29	**154**	**33%**			
	7	8	7	5										
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	11	4	11	8	**34**	75	76	74	28	**253**	**13%**			
	n/a	n/a	n/a	1										
Proportion of mothers of children age 12–23 months who purify drinking water	11	22	15	18	**66**	41	47	37	29	**154**	**43%**			
	12	14	11	9										
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	12	7	12	5	**36**	55	32	51	14	**152**	**24%**			
	8	3	7	1										
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday (As recorded in card or ; Denominator: Children age 12-23 months whose cards were seen by interviewer)	19	18	7	10	**54**	34	29	25	20	**108**	**50%**			
	12	10	9	7										
Proportion of children age 12–23 months who received a measles vaccine (As reported by mother or recorded in card; Denominator: Children age 12-23 months)	32	35	21	19	**107**	41	47	37	29	**154**	**69%**			
	23	27	21	17										
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	2	4	5	4	**15**	34	34	28	22	**118**	**13%**			
	1	1	1	n/a										
Proportion of mothers with children age 0–11 months who received at least two tetanus toxoid injections before the birth of their youngest child	14	7	4	19	**44**	54	48	55	69	**226**	**19%**			
	5	4	5	7										
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	8	6	12	20	**46**	22	29	30	29	**110**	**42%**			
	7	9	9	9										
Proportion of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	13	5	9	11	**38**	23	12	15	21	**71**	**54%**			
	10	5	6	9										
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	17	11	11	24	**63**	32	19	55	69	**175**	**36%**			
	8	5	13	n/a										
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	29	34	23	20	**106**	41	47	37	29	**154**	**69%**			
	23	27	21	17										
Proportion of children 6-23 months who received Vitamin A supplement within the last 4-6 months according to age standards	46	45	34	44	**169**	73	66	92	98	**329**	**51%**			
	n/a	n/a	n/a	n/a										

ANNEX 4: Behavior Change Strategy Formative Research Plan

HIV / AIDS What do we know?

Behavior	Facilitators	Barriers	Further formative research questions for project
Consistent use of condoms by youth aged 15-24 while with a non-union partner	Condoms are sometimes available free of charge through community outlets Influence by peers Increased testimonials from young people living with AIDS	Difficulty for female youth to negotiate condom use Price of socially marketed condoms Image of women who request condoms/attitudes Beliefs and taboos about use of condoms – perception that decrease virility, causes allergies	What differentiates those who are out of union who regularly use condoms from those who do not, for both sexes? What difficulties do youth faith in using the condom? What questions do they have? What skills are needed to negotiate safe sexual practices? Where are "safe" distribution points for condoms for both young men and women? What is the social norm regarding condom use?
Sexually active youth use modern contraceptive method	Contraceptives available free of charge at HCs Favorable government policy towards family planning methods	Negative attitude among group about contraceptives Perception of stigma at health services Real side-effects	Attitudes about adolescent pregnancy among young men and women? How accessible are health services to youth? What contraceptives do youth like best and why? What problems have youth had using contraceptives?
Delay first sexual intercourse encounter of adolescents	Value system Strength of social norms to set standards	Some youth believe desirable to start child rearing early Poverty / sexual favors for gifts Lack of positive information/messages	Factors influencing sexual debut Alternative income generating activities for female youth

WHAT DO WE KNOW? Diarrhea

Behavior	Facilitators	Barriers	Further formative research questions for project
Families treat home drinking water with chlorine and store in proper storage container with narrow neck	Social marketing of PUR tablets and upcoming social marketing of chlorine solution Community distribution of household amounts of commercial chlorine solution (JIF is a commercial name) Taste indicates that its "clean" High level of risk perception / public	Cost of treatment Cost of storage container Some family members don't like taste	Are one gallon plastic containers with lids used for home water storage? Are people willing to pay for them (costs 10-100 gdes)? Who treats the water at home and how well do they measure solution amounts? What do they use? What differentiates those who treat their water from those who do not?

Behavior	Facilitators	Barriers	Further formative research questions for project
	testing of water sources		
Mother increasing fluids and maintaining frequent feeding of child with diarrhea	Mother wants child to recover quickly Most children are breastfed	Very strong belief in "drying" the child Lack of child appetite Awareness of importance of rehydrating child with diarrhea	What are local beliefs about causes and treatment of diarrhea (by each of the 3 types)? Learn more about teething "yae" and heat –"tisane" What kinds of inexpensive complementary foods can be promoted? How can busy mothers best find time to care for feeding needs of sick child? How skilled are mothers in active feeding?
Caretakers of children with diarrhea correctly prepare and give ORS	Vending points readily available Most mothers are familiar with ORS Mothers prefer to treat at home to save time and money	Only 40% knew how to accurately prepare ORS Cost: Distribution sites biased to sell Sel Lavi a socially marketed product instead of free packets from UNICEF Stock-outs of both social marketing and subsidized products.	Do mothers think that ORS is effective? What do they think it does? Do mothers understand the concept of dehydration? What are known symptoms in Creole? How much are mothers willing and able to pay for ORS? Who do they trust to get ORS from? Who can best help mothers to learn how to prepare ORS? What needs to improve in their understanding on how to prepare it?
Promptly seeking care at the Health Center when child presents bloody diarrhea or persistent diarrhea of 14 days or more, or if acute watery diarrhea persists after ORS treatment	Health centers staffed with nurses and usually a doctor	Diarrhea viewed as normal and parents too tired to bring to health center Fee for consultation $1 - $1.50 + lab and treatment costs Limited hours of service at health centers Perceived low quality of care	What are local terms for acute watery, persistent, and bloody diarrhea (by each of the 3 types)? What are perceived causes and how is each treated? Acceptability and factors influencing timeliness of visit to health center
Handwashing at critical times with soap	Availability of low cost soap and some access to cash More educated groups aware of risks of disease spread through hands	Extremely limited and expensive water supply Public facilities including at HCs have no handwashing facility	Acceptability and options for handwashing points in the home Options for public handwashing points (building on paid showers)

WHAT DO WE KNOW? Pneumonia

Behavior	Facilitators	Barriers	Further formative research questions for project
Mothers promptly identify danger signs of the newborn and child and promptly seek care at the Health Center	Health centers with staffed with nurses and usually a doctor nearby Most sick children seen first at health center	Some mothers tendency to first seek care from informal providers Quality of case management Pneumonia as a illness is not known and considered with variety of respiratory problems such as asthma Fee for consultation $1 - $1.50 + treatment costs	What are the respiratory diseases known by mothers? Do they distinguish specific symptoms of pneumonia and what are local terms for these? Acceptability and factors influencing timeliness of visit to health center
Health providers effectively assess, classify, treat and counsel mothers	Mothers want to learn and receptive to health worker advice Providers willing to learn	Overlapping presentation of symptoms of malaria and pneumonia Limited standard case management skill of health providers, absence of job aides Availability of laboratory services to confirm malaria parasites Consultation time only 5-10 minutes maximum	Provider and mothers' beliefs about sick child feeding Consultation time analysis and patient flows Antibiotic prescription beliefs, attitudes and counseling and home practices
Mothers provide full treatment of antibiotics and increased fluids and maintain feedings for sick child with pneumonia	Antibiotics available for low cost at health facility Health providers willing to work harder to counsel mothers Mothers want child to recover quickly and not get sick again	Perceived need to share antibiotics with other family members to protect them from the illness Difficult to feed sick child, lack time, skills and confidence Duration and cost of treatment	Common home remedies for children with pneumonia symptoms Beliefs and attitudes about sharing drugs in the home Beliefs about feeding sick child and recuperative feeding. Beliefs in improvement of sick child with early treatment.

Immunizations - What do we know?

Behavior	Facilitators	Barriers	Further formative research questions for project
*Health providers screen vaccination status of all children and administer vaccine	Reliable supply of vaccines and staff to provide vaccination at two of the health facilities Child card includes vaccination status Providers motivated to achieve high coverage of vaccination Screening step included in national IMCI protocols	Belief that better to postpone vaccination of a sick child Counseling efficacy of service provider to persuade mother that vaccination is safe One facility does not have routine vaccination service on-site Limited skill of health providers Consultation time only 5-10 minutes maximum	Observation of case management of sick child and missed opportunities Attitudes and beliefs of service providers about administration of vaccines to sick child Opportunities for extending vaccination services at non-fixed site at Cite Okay
Mothers of children under-one bring child to health facility every month for first 3 months and before 1st birthday for the purpose of vaccinations	Mothers want child to be healthy for peace of mind and conserve caretaking time Mothers understand importance of vaccines Vaccines are free	Mothers awareness of vaccination schedule Health facility crowded and long waiting times Sometimes has to pay consultation fee Misperception of side effects of vaccinations	Mother's awareness of what vaccinations do, the schedule Convenience and improvements in service schedule Community involvement in organization of services
*Health providers proactively seek tetanus toxoid protection for women of childbearing age	High participation of mothers in antenatal care TT status including on mother's card Health workers motivated to eliminate neonatal tetanus	Difficulty knowing TT status lifetime Conservatism in opening TT vial Mothers don't ask for the TT	Beliefs and practices of health workers Perceptions and beliefs of mothers

Nutrition - What do we know?

Behavior	Facilitators	Barriers	Further formative research questions for project
Mother frequently and exclusively feeds infant under six month breastmilk	Breastfeeding is a social norm Free Actual consequences in terms of reduced incidence of diseases	Mother works outside the home, baby can't always be with her Mother tired, needs time Mother's perception that she doesn't have enough milk	Beliefs about breastfeeding, its adequacy Types of problems and local terms that mothers face with breastfeeding **Differences between doers and non/doers of exclusive breastfeeding after 3 months of age**important**
*Mother provides at least 3 complementary	Breastfeeding is a social norm	Availability of weaning foods in the home	Local availability of complementary foods

Behavior	Facilitators	Barriers	Further formative research questions for project
feeds plus breastmilk for infant 6-9 months	Availability of health facility staff and community social leaders to advise	Mother's self-efficacy for active feeding Early full weaning of child at 3 months	Norms and taboos about weaning
*Complementary foods for child are stored in clean and covered containers and cooked with boiled or treated water	Mother motivated to keep child healthy and low maintenance	Absence of basic utensils/dishes in the home Unsafe water in very limited quantities Extremely poor families more likely to purchase foods in small quantities from vendors rather than cook at home (money for fuel)	Observation of food storage practices Mothers beliefs and attitudes about food hygiene
Mother seeks Vitamin A supplementation every six months for child 6 to 59 months	Organized campaigns achieve good coverage Regular supply at HC Free	Importance of Vitamin A not well known Children who don't go to HC have poor access	Beliefs about Vitamin A supplements, local terms

Maternal & Newborn Care What do we know already?

Behavior	**Facilitators**	**Barriers**	**Further formative research questions for project**
Families recognize danger signs of pregnancy, postpartum and newborn and go straight to the hospital	Parents and family want safe outcome of pregnancy Availability of multiple information channels to reach men and women Efforts underway to improve obstetric service quality at hospitals	Low skills in identifying urgent danger signs Insecurity to travel at night out through some parts of the neighborhood Fear that going to hospital will be very expensive and mother will have to have a C-Section.	What experiences are known in each of the communities of problems during pregnancy, postpartum and the newborn? What are local terms and believed underlying causes? Listing actual costs and availability of services.
Mothers purchase and use a clean delivery kit	Desire to protect mother and newborn Planned intervention to make kits available at health centers at less than 80 gourdes)	Scarce disposable income Kits not yet available	Willingness to pay for clean delivery kits by mothers and fathers.

Behavior	Facilitators	Barriers	Further formative research questions for project
Families recognize danger signs of pregnancy, postpartum and newborn and go straight to the hospital	Parents and family want safe outcome of pregnancy Availability of multiple information channels to reach men and women Efforts underway to improve obstetric service quality at hospitals	Low skills in identifying urgent danger signs Insecurity to travel at night out through some parts of the neighborhood Fear that going to hospital will be very expensive and mother will have to have a C-Section.	What experiences are known in each of the communities of problems during pregnancy, postpartum and the newborn? What are local terms and believed underlying causes? Listing actual costs and availability of services.
Mothers purchase and use a clean delivery kit	Desire to protect mother and newborn Planned intervention to make kits available at health centers at less than 80 gourdes)	Scarce disposable income Kits not yet available	Willingness to pay for clean delivery kits by mothers and fathers.
TBAs and Auxillary Nurses conduct postpartum visits in mother's homes within 48 hours of delivery[1]	It is socially accepted standard for TBAs to visit home during postpartum period Already practice for TBA to wash newborn	Many women deliver without TBAs so no postpartum consultation from trained person in their case TBAs don't have good relationship with hospitals Timeliness of referral and family take-up of recommendation to seek care	Identify factors influencing choice to have TBA attendance at delivery Existing postpartum caring practices by TBAs Perceptions of cause and locally undertood definition of excessive postpartum bleeding and sepsis.

[1] Behavior modified to reflect correction in national policy interpretation which permits postpartum consultations by trained TBAs and auxillary workers.

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A Partnership of Concern Worldwide, FOCAS, and GRET with the Ministry West Department

Project Period: October 1, 2005 - September 30, 2010

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- Eugène Emmanuel Narlhem
- Marcdert Deus
- Waldeck Junior Demetrius
- Mackenson Sylvestre
- James Junior Alexandre
- Jean Claude Balthazar
- Jean Addony Thezalus

Finally he would like to express his sincere gratitude to all the health personnel and CBO members from each of the neighbourhoods for their excellent support in community mobilization and assistance with the surveys.

1 BACKGROUND

A. Description of Project Area

The project area comprises five urban slum areas of Port-au-Prince, in Haiti, with a total population of 218,490. The number of total direct beneficiaries is estimated to be 85,169 (32,555 children under five years of age and 52,614 women of reproductive age). The beneficiaries live in slums characterized by unplanned urbanization. There is a severe lack of public services, including health services, resulting in unacceptable quality and access. Just over one-half of households are female headed. Only about half of the Port-au-Prince population has access to improved sanitation facilities, such as latrines, and only 40% have access to potable water. Table 1 summarizes population estimates for the five slums.

Table 1: Estimated project population

	Project Area	*Partner*	*Commune*	*Total Population*
1	Senmaten	Concern	Delmas	75,000
2	Site Okay/Jeremie	Concern	Delmas	25,000
3	Dekayet	GRET	Port-au-Prince	50,000
4	Jalouzi	FOCAS	Petion-Ville	54,758
5	Bwa Mokèt	FOCAS	Petion-Ville	13,732
			Total	***218,490***

Source: Project proposal, 2004; Population of Dekayet – GRET estimate 2006.

B. Health Status of the Project Population

The health situation in Haiti is appalling. At 523 deaths/100,000 live births, the maternal mortality rate is the worst in the western hemisphere. Major causes of maternal death are obstetric complications during home delivery resulting from poor or no professional care. HIV/AIDS is a growing cause of women's illness and death during their reproductive life. National child mortality rates in Haiti are the worst in the western hemisphere. National infant mortality is estimated to be 80.3 deaths/1,000 live births, and under-five mortality is 118.6/1,000. One-quarter of all under-five deaths occur among neonates during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths, while major causes of mortality for under-five children are acute respiratory infections, diarrhea, and nutrition. HIV/AIDS is quickly eroding gains made in maternal and child health with an estimated adult seroprevalence of 3.5%.

FOCAS and its non-governmental organization partners conducted a maternal and neonatal health care assessment in Petion-Ville Commune from February – March 2002, and found the following serious problems: trained matrones (traditional birth attendants) demonstrated basic deficiencies in quality of care, especially in recognizing and seeking care for life-threatening obstetrical complications during labor and delivery; many women delayed seeking emergency obstetrical care because they did not have the money to pay for transportation or for the hospital care; many women believed they would receive poor quality care if they did go to the hospital; and community members and community-based organizations were not involved formally in the prevention of, and in the response to, obstetrical and neonatal emergencies.

Separately, Concern conducted an immunization coverage survey in Senmaten during July 2002, and found that only 14% of children were completely vaccinated, although 40% had completed their vaccinations schedules for polio and DPT. BCG and

measles coverage rates were 84% and 64%, respectively. Less than 50% of pregnant women in Senmaten had two TT injections prior to delivery. Concern found both institutional barriers (high number of clinic visits required to complete all vaccinations, many missed opportunities, periodic stock-outs, and limited hours of service) and client barriers (lack of women's time to bring a child for services, and lack of knowledge among parents regarding the importance of vaccinations in general, and the vaccination schedule in particular).

Also, a 2001 nutritional study conducted by Concern in Senmaten indicated a daily struggle among families to secure food. Parents generally demonstrated knowledge regarding ideal foods, but their consumption depended upon daily income. Among other important results, the study found that most mothers did not exclusively breastfeed for six months, and the introduction of liquid and solid foods commonly occurred by the third month.

C. Socioeconomic Characteristics of the Population

Haiti's current population is just under 8 million. Forty percent of the population is 15 years old or younger, and the annual growth rate is calculated to be 2.08%. Given its relatively small land mass, Haiti has one of the highest population densities in all of Latin America. The national fertility rate is calculated to be 4.8%, while the average life expectancy is 53 years. An additional 2 million people are believed to be living outside the country. Seventy percent of the population lives in absolute poverty, with a per capita annual GNP of $507.

Half the national population is reportedly literate, with males (52%) slightly better educated than women (47.8%). The net primary school enrollment (i.e., the proportion of the total eligible population actually attending school) is 68%, and girls have 0.5 to 2.0 fewer years of schooling than do boys. Fourteen percent of mothers with children less than five years of age have no schooling, and only 18% have completed secondary school or higher.

The Port-au-Prince metropolitan area is home to one out of every four Haitians, or about 2 million people, with an average household size of 4.72. The metro area population growth rate is 5% per year, including significant rural in-migration. Two-thirds of a representative sample of the population of Port-au-Prince earns less than $25 US per month, making it one of the poorest cities in the world. Residents of these neighborhoods are employed, if at all, in the informal sector of petty trade and hawking. There is significant migration within and across the slums due to violence, economic hardships, and natural disasters. The majority of households are female headed in the metropolitan area (51%), with fewer (38%) in the rural areas.

Most of the very poor live in marginal neighborhoods or slums characterized by unplanned urbanization. There is a severe lack of public services, and little regulation of schools or health services, resulting in unacceptable quality and access across sectors. The state of housing, overpopulation, and hygiene is at its worst in the poorest of the poor neighborhoods which are situated along the coast, water ways through the city, or on hilltops. These also are the neighborhoods that are most vulnerable to natural disasters, such as floods and landslides.

Only about half of the urban population has access to improved sanitation facilities, such as latrines. There are no urban sewage systems in the country. Forty-nine percent of the country's urban population has access to potable water, 40% in Port-au-Prince. FOCAS recently conducted a water quality study in Petion-Ville that found 97% of all tested drinking water sources were fecally contaminated. Families spent about 10% of their income to purchase about 12 liters of water per day.

The majority of homes in the slum areas can be accessed only by means of small 'corridors,' which crisscross the neighborhoods. These corridors serve not only as a means of access but also as living spaces where people wash, cook, eat, and where children play. A majority of corridors are unpaved and form a muddy, dirty environment where rubbish and sewage collect next to homes, creating serious health risks to children. There are no garbage removal services.

Poverty, unemployment and drugs fuel gangs of armed youth. The police largely are absent in Port-au-Prince slums, and the justice system is non-functional, creating a climate of insecurity and fear. In some neighborhoods, wars between gangs based on territorial control or political conflicts have paralyzed activities for weeks and forced families to flee for their lives.

D. Project Goal and Objectives

The goal of the project is to lower maternal and childhood mortality through improved health service provision and usage within five slum areas of Port-au-Prince, reaching about 10 percent of the city's population. Specific objectives include:

- Increase the proportion of women who had four antenatal care visits during their last pregnancy
- Increase the proportion of women whose last birth was attended by a trained provider
- Increase the proportion of unmarried youth 15-24 years who report abstaining from sex for 12 months
- Increase the proportion of men and women aged 15-49 years who have been tested for HIV and know their status
- Increase the proportion of households with children in which drinking water is purified
- Increase the proportion of children less than two years with diarrhea who receive ORS and zinc
- Increase the proportion of children 12–84 months who received Vitamin A supplement within the past 4 months
- Increase the proportion of children under two years of age with symptoms of pneumonia seen by trained provider
- Increase the proportion of children 12-23 months of age fully vaccinated by their first birthday

E. Project Strategy and Interventions

The project will:

- Strengthen the quality and range of government and non-profit health clinic services
- Build family and community capacity to prevent unnecessary illness and death
- Increase the capacities of key Ministry of Health structures and of partners to implement, integrated, community-based health projects in urban settings

The anticipated level of effort for this project is as follows: maternal and newborn care (25%); HIV/AIDS prevention (20%), control of diarrheal disease (20%); pneumonia case management (20%); and immunization (15%).

F. Objectives of the Survey

The objectives of the survey were:

- To obtain population-based information on key knowledge, practices and coverage from mothers of children age 0-23 months.
- To prioritize interventions and refine targets for the project.

II. METHODS

A. Questionnaires

Two survey questionnaires were designed, the first for mothers with children 0-11 months of age and the second for those with children 12-23 months. Two modules were included in both questionnaires (demographic information and management of childhood illness). The questionnaire for mothers with children 0-11 month also included modules on maternal and newborn care and nutrition. The one for mothers with children 12-23 months contained modules on water and sanitation, HIV/AIDS and other sexually transmitted infections, childhood immunization, and sources of health information.

The questionnaires were initially prepared in French and then translated into Kreyol by the project team. See Annexure for a copy of the questionnaires.

B. Sampling Design

The survey utilized simple random sampling within each of two survey sites (Bwa Mokèt and Jalouzi comprised one site and Site Okay/Jeremie the second). The sampling method was similar to that used in the lot quality technique. However, the purpose of the sampling was not to determine if lots were "adequate" or not in terms of health knowledge, practices, and coverage but to estimate aggregated values for health indicators for each site. However, methods applied during the survey can form the basis for future monitoring efforts based on the lot quality technique.

In both survey sites, survey teams delineated five supervision zones which were more or less comparable in terms of population size and can be useful for future planning, assigning supervisory responsibilities, and monitoring. Streets, corridors, and prominent buildings were all used in identifying boundaries of the zones.

Within each zone, maps were prepared for nineteen randomly identified sub-divisions. One household was randomly identified in each sub-division for the survey team to visit on the interview date for that area.

C. Training of Supervisors and Interviewers

Training of supervisors and interviewers was carried out by the survey Core Team (comprised of representatives of Concern, FOCAS, and GRET). Supervisors were also drawn from the three organizations. HaitiMed, an organization that provides health care services in Site Okay/Jeremie, also contributed a supervisor. Similarly, Concern, FOCAS, and GRET identified staff from community-based organizations to conduct interviews.

Supervisors joined the Core Team on the first day of training. This was followed by three days of training for both supervisors and interviewers, of which one was used for practice interviews in St. Claire, a community that is not part of the Child Survival project.

D. Data Collection

The survey was conducted over a two-week period from March 6 – 17, 2006. There were eight teams with two interviewers and one supervisor in each team. The supervisor of each team was responsible for randomly selecting the starting household and helping the interviewers in randomly identifying a household for interview if the first household did not have any eligible mothers. Supervisors also observed at least one complete interview each day.

In order to obtain consent and assure respondents of confidentiality, interviewers read out a consent form to the mother before starting the interview. Interviews took between 20 and 45 minutes to complete.

E. Data Analysis

Data were entered into a computer database using EpiInfo. The same software package was used for data analysis. The Household Dietary Diversity Survey (HDDS) was applied as a proxy for social-economic status. Mothers were asked about the types of food family members ate the previous day. Interviewers mentioned twelve types (such as bread, vegetables, fruit, and eggs) and noted for each whether the mother reported the food as having been consumed. Results were categorized into quintiles and key coverage and practice indicators stratified by HDDS quintile to assess equity of health status at baseline.

III. RESULTS

Table 2: Baseline Survey Results: Child Survival Project Indicator Values

Indicator	Num	Den	%	LCL (%)	UCL (%)
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	115	225	51	44	57
Proportion of mothers of children age 0–11 months whose last delivery was attended by a traditional birth attendant	104	225	46	40	53
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	77	225	34	28	41
Proportion of mothers of children age 12–23 months who demonstrate an accepting attitude toward people living with HIV/AIDS	14	149	9	5	15
Proportion of mothers of children age 12–23 months who purify drinking water	48	149	32	25	40
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	92	185	50	42	57
Proportion of children less than two years old with diarrhea in the past two weeks who received oral	4	185	2	1	5

Indicator	Num	Den	%	LCL (%)	UCL (%)
rehydration solution and zinc					
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	60	117	51	42	61
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	101	149	68	60	75
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	51	77	66	54	77
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	8	77	10	5	19
Proportion of mothers with a child 12-23 months who know at least three symptoms of pneumonia	1	149	1	0	4
Proportion of children age 12–23 months who have received the DPT1 vaccine	86	101	85	77	91
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	15	86	17	9	26
Proportion of mothers of children age 0–11 months who received at least 90 days of iron and folate in last pregnancy	9	225	4	2	8
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	36	225	16	12	22

Note: (1) Num = Numerator, Den = Denominator, % = Percent, LCL = Lower confidence limit, UCL = Upper confidence limit (2) All values have been rounded. (3) Percent values were calculated using actual values of numerators and denominators, which because of weighting often contained fractional parts. If percent values are computed using the rounded numerators and denominators displayed here, they may not match values in the table exactly.

Table 3: Baseline Survey Results: Rapid CATCH Findings

Indicator	Num	Den	%	LCL (%)	UCL (%)
Proportion of children age 0–23 months who were born at least 24 months after the previous surviving child	74	107	69	59	78
Proportion of children age 0–11 months whose births were attended by skilled health personnel	98	225	44	37	50
Proportion of mothers with children age 0–11 months who received at least two tetanus toxoid injections before the birth of their youngest child	43	225	19	14	25
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	31	108	28	20	38
Proportion of children age 6–9 months who received	38	74	52	40	64

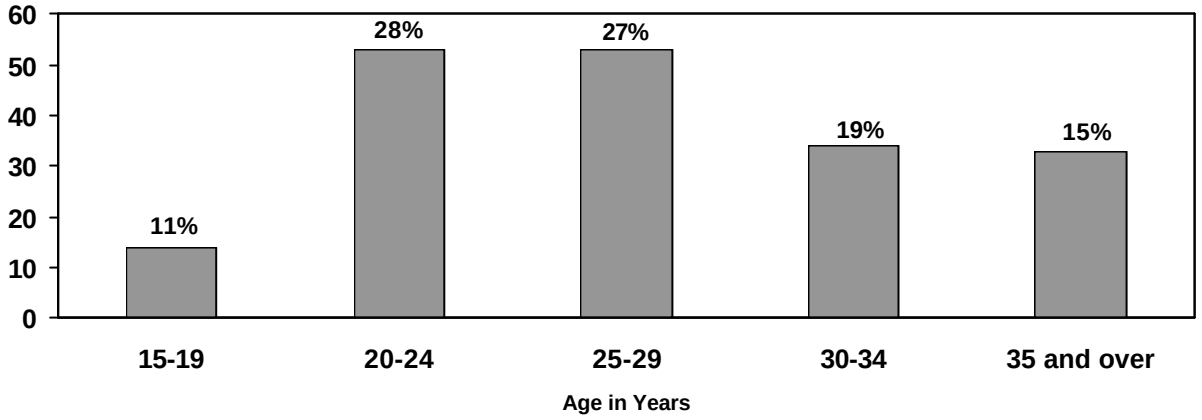
Indicator	Num	Den	%	LCL (%)	UCL (%)
breastmilk and complementary foods during the last 24 hours					
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	51	101	51	40	61
Proportion of children age 12–23 months who received a measles vaccine	62	101	61	51	71
Proportion of children age 12–23 months who slept under an insecticide-treated net the previous night	4	149	3	1	7
Mothers with children age 12–23 months who cite at least two known ways of reducing the risk of HIV infection	133	149	89	82	93
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	4	149	3	1	7
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	47	149	32	24	40
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	38	297	13	9	17

Note: (1) Num = Numerator, Den = Denominator, % = Percent, LCL = Lower confidence limit, UCL = Upper confidence limit (2) All values have been rounded. (3) Percent values were calculated using actual values of numerators and denominators, which because of weighting often contained fractional parts. If percent values are computed using the rounded numerators and denominators displayed here, they may not match values in the table exactly.

A. Demographic Information

In the Port-au-Prince Child Survival Project target area, the mean age reported by mothers who were interviewed was 27 years. Graph 1 below shows the age distribution of mothers.

Graph 1: Age Distribution of Mothers



Among the children in the survey, 60% were under the age of one year (11 months of age or younger) and 40% of the children were 12-23 months of age. The mean age of children in the survey was 10 months. Of the 374 children, 54% were male and 46% were female. The age and sex distribution of children is presented in Table 4.

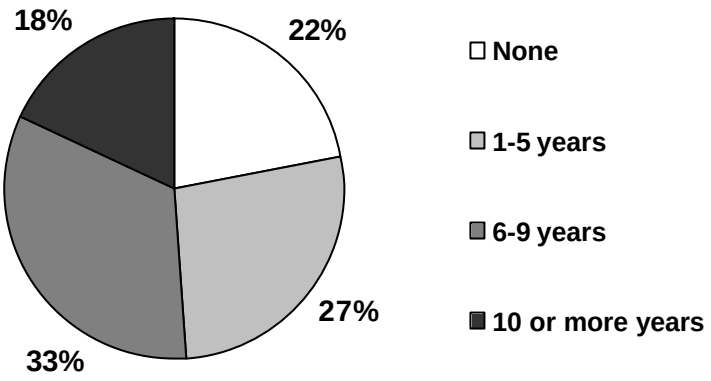
Table 4: Age and sex of children

AGE	MALE	FEMALE	TOTAL
0-5 months	55	53	108
6-11 months	67	50	117
12-23 months	80	69	149
Total	202	172	374

Most mothers (87%) said they did not work outside the home. Of those who reported working outside the home, 67% said they were shopkeepers or street vendors. Husbands, partners, grandmothers, and other relatives cared for the children while mothers were away at work.

Graph 2 shows the educational attainment of mothers. Twenty-two percent had not attended school. Only 18% had attended school for 10 or more years. With nearly half the mothers reporting only a primary education or none at all, health education messages need to be delivered through non-literate materials in project areas.

Graph 2: Years of School Attended by Mothers



B. HIV/AIDS and other Sexually Transmitted Infections

Knowledge

Mothers with children 12-23 months of age (149) were asked if they had heard of AIDS. All but one answered in the affirmative. They were also asked about ways of reducing the risk of getting infected with HIV (having just one sex partner who is not infected and who has no other partners, using a condom, and abstaining from sexual intercourse). Ninety-six percent of mothers recognized at least one way; seventy percent recognized three. Mothers with children age 0-11 months were asked about ways of transmission of HIV from a mother to the child. Sixty-nine percent recognized at least two ways; 46% recognized three (see Table 5).

Table 5: Mothers' recognition of ways HIV/AIDS can be transmitted from mother to child

NUMBER OF WAYS HIV/AIDS CAN BE TRANSMITTED FROM MOTHER TO CHILD	NO. (%) OF MOTHERS
0	30 (13%)
1	40 (18%)
2	52 (23%)
3	103 (46%)1
Total	225

Mothers with children 12-23 months were also asked whether they had heard about other infections transmitted through sexual contact, apart from HIV. Seventy-three percent reported that they had heard about other infections. Forty-nine percent of the mothers who had heard about other infections knew three or more signs and symptoms of such sexually transmitted infections.

[1] Throughout the report, percentages in tables may not add up to 100% due to rounding.

Attitudes

In addition to assessing knowledge, survey interviewers asked questions to ascertain attitudes of mothers with children 12-23 months towards people living with HIV/AIDS. Sixteen percent said they would buy food from a vendor known to be HIV-positive. If a relative of the mother became infected with HIV, 69% said they would not want it to remain a secret. Forty-eight percent reported they would be willing to care for a relative if he or she became sick with the AIDS virus.

C. Diarrheal Disease Management and Prevention

Knowledge

Mothers with children 12-23 months of age (149) were asked to describe how they would prepare oral rehydration solution if needed. Sixty-eight provided a correct description (46%).

Practice

One hundred eighty-five mothers with children less than 24 months of age (50%) reported that their child had experienced an episode of diarrhea in the two weeks prior to the survey. Ninety-two said they gave oral rehydration solution to the child (50%).

Table 6 presents information on the breastfeeding practices of mothers during the child's diarrheal episode. Of the 150 mothers who were breastfeeding the child before the episode, 121 breastfed the same or more than usual during the episode (81%).

Table 6: Breastfeeding practices of mothers for children with diarrhea

BREASTFEEDING DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	27 (15%)
Same as before diarrheal episode	50 (28%)
More than usual	71 (39%)
Child not breastfed (before and during diarrheal episode)	32 (18%)
Mother did not know	1 (1%)
Total	182

Table 7 summarizes the feeding practices of mothers during the child's diarrheal episode. Of the 139 mothers who were giving foods other than breast milk to the child before the episode, 48 gave the same or more amount of food during the episode (35%).

Table 7: Food given to children with diarrhea

FEEDING DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	90 (49%)
Same as before diarrheal episode	27 (15%)
More than usual	21 (11%)
No food (other than breast milk)	45 (24%)
Mother did not know	1 (1%)

Total	184

Table 8 describes the practice of mothers in giving fluids during the child's diarrheal episode. Of the 173 mothers who were giving fluids other than breast milk to the child before the episode, 64 gave more fluids during the episode (37%).

Table 8: Fluids given to children with diarrhea

FLUIDS DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	63 (34%)
Same as before diarrheal episode	45 (25%)
More than usual	64 (35%)
No fluids (other than breast milk)	11 (6%)
Mother did not know	1 (1%)
Total	184

Interviewers also asked mothers of children 12-23 months (149) about drinking water and sanitation practices. Forty-eight mothers (32%) reported purifying their drinking water.

Table 9 presents information about 128 mothers who responded to a question about their hand washing practices. Sixty-five percent reported washing their hands with soap after defecation. Only four mothers said they washed their hands with soap at all four times (before preparing food, before feeding children, after defecation, and after attending to a child who has defecated).

Table 9: Mothers' hand washing practices*

WHEN RESPONDENTS WASH HANDS WITH SOAP	***NO. (%) OF MOTHERS***
Before preparing food	*47 (37%)*
Before feeding children	*40 (31%)*
After defecation	*87 (68%)*
After attending to a child who had defecated	*32 (25%)*

** The sum of numbers is greater than 128 and the sum of percentages exceeds 100% because multiple responses were allowed.*

D. Nutrition

Practice

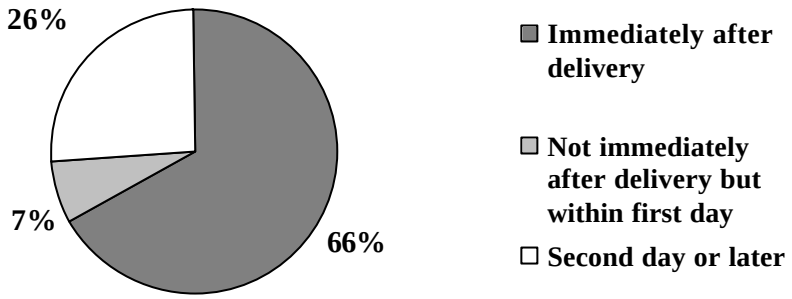
All mothers (374) were asked about the types of food family members ate the previous day. Interviewers mentioned twelve types (such as bread, vegetables, fruit, and eggs) and noted for each whether the mother reported the food as having been consumed. Table 10 summarizes responses given by mothers.

Table 10: Number of food types eaten by family members the previous day

NUMBER OF FOOD TYPES	No. (%) OF MOTHERS
Four or less	67 (18%)
Five to eight	239 (64%)
Nine or more	68 (18%)
Total	374

Mothers with children 0-11 months (222) were asked if they ever breastfed the child. Two hundred sixteen (97%) responded positively. As shown in graph 3, of the 214 mothers who remembered when they first put the child to the breast, 66% said that they put their child to the breast immediately after delivery.

Graph 3: Initiation of Breastfeeding



One hundred seventy-seven (82%) mothers remembered giving colostrum to the child. Two hundred five were still breastfeeding the child at the time of the survey. Of 108 children 0-5 months of age, 31 were exclusively breastfed (28%). Of 74 children 6-9 months of age, 38 received breast milk and complementary foods (52%) during the last 24 hours.

One hundred sixty-one of 266 mothers of children 6-23 months of age reported that the child recently received a dose of vitamin A (61%). For children younger than 12 months, this meant a dose within the last six months, and for older children, within the last four months.

Table: Distribution of Mid-Upper Arm Circumference, children 12-23 months

MUAC Measurement (in mm)	Number	%
<110mm	0	0%
110-125	2	1%
126-150	67	45%
151+	79	53%
Total	148	

Missing and erroneous records for 5 children

E. Pneumonia Case Management

Knowledge

As shown in Table 11, few mothers knew the symptoms of childhood pneumonia. Of 149 mothers of children 12-23 months, only one knew three or more symptoms.

Table 11: Mothers' knowledge of symptoms of childhood penumonia*

SYMPTOM	NO. (%) OF MOTHERS
Fast breathing	12 (8%)
Difficult breathing	*11 (7%)*
Fever	*4 (3%)*
Chest indrawing	*0 (0%)*

** Multiple responses were allowed.*

Practice

Seventy-seven mothers of children 0-23 months (21%) reported that their child had an illness with cough and rapid or difficult breathing in the two weeks prior to the survey. Sixty (78%) reported they sought advice or treatment for the illness. Fifty-one children (66%) were taken to a health facility for the illness.

Of 60 mothers who responded to a question about the day on which treatment was sought after noticing symptoms, fourteen (23%) said "same day" (see Table 12).

Table 12: Time taken to seek treatment for child with cough and rapid or difficult breathing

DAY ON WHICH TREATMENT SOUGHT AFTER NOTICING SYMPTOMS	NO. (%) OF MOTHERS/CAREGIVERS
Same day (day 0)	14 (23%)
Next day (day 1)	9 (15%)
Day 2	6 (10%)
Day 3 or later	31 (52%)
TOTAL	60 (100%)

Table 13 presents information on the breastfeeding practices of mothers during the child's illness. Of the 61 mothers who were breastfeeding the child before the illness, 47 breastfed the same or more than usual (77%) during the illness.

Table 13: Breastfeeding practices of mothers for children with cough and rapid or difficult breathing

BREASTFEEDING DURING ILLNESS WITH COUGH AND RAPID OR DIFFICULT BREATHING	No. (%) OF MOTHERS
Less than usual	14 (20%)
Same as before illness	16 (21%)
More than usual	31 (42%)
Child not breastfed (before and during illness)	13 (17%)
Total	74

Table 14 summarizes the feeding practices of mothers during the child's illness. Of the 56 mothers who were giving foods other than breast milk to the child before the illness, fourteen gave the same or more amount of food during the illness (25%).

Table 14: Food given to children with cough and rapid or difficult breathing

FEEDING DURING ILLNESS WITH	No. (%) OF MOTHERS

COUGH AND RAPID OR DIFFICULT BREATHING	
Less than usual	42 (56%)
Same as before illness	7 (10%)
More than usual	7 (9%)
No food (other than breast milk)	18 (25%)
Total	74

Table 15 describes the practice of mothers in giving fluids during the child's illness. Of the 66 mothers who were giving fluids other than breast milk to the child before the illness, 19 gave more fluids during the illness (29%).

Table 15: Fluids given to children with cough and rapid or difficult breathing

FLUIDS DURING ILLNESS WITH COUGH AND RAPID OR DIFFICULT BREATHING	**No. (%) OF MOTHERS**
Less than usual	29 (38%)
Same as before illness	19 (25%)
More than usual	19 (26%)
No fluids (other than breast milk)	9 (11%)
Total	75

In all, eight of 77 children 0-23 months (10%) with cough and rapid or difficult breathing received more fluids and were fed as before.

F. Vaccine Coverage

Of the 149 children 12-23 months in the survey, interviewers were able to examine vaccine cards for 101 children (68%). Table 16 presents card-confirmed coverage with specific vaccines among the 101 children. If children are classified as vaccinated if they received the vaccines any time before the interview date, seventy children (70%) were found to be fully vaccinated against diphtheria, pertussis, tetanus, polio, and measles. Sixty-five children (65%) were fully vaccinated against these five diseases and tuberculosis.

If children are classified as vaccinated only if they received the vaccines by their first birthday, 51 were fully vaccinated (51%) against diphtheria, pertussis, tetanus, polio, and measles. Forty-two children (42%) were fully vaccinated against these five diseases and tuberculosis. The drop out rate between the first and third dose of the vaccine against diphtheria, pertussis, and tetanus was 17% (as 86 children received the first dose and 71 the third dose).

Table 16: Card-confirmed vaccine coverage for children 12-23 months of age

VACCINE	**VACCINES RECEIVED ANY TIME BEFORE INTERVIEW DATE**	**VACCINES RECEIVED BY FIRST BIRTHDAY**
	No. (%) OF CHILDREN	**No. (%) OF CHILDREN**
BCG	88 (88%)	77 (77%)
Polio 1	96 (95%)	90 (89%)
Polio 2	90 (90%)	78 (77%)
Polio 3	79 (78%)	66 (66%)
DPT 1	96 (96%)	86 (85%)
DPT 2	92 (92%)	83 (82%)
DPT 3	85 (84%)	71 (70%)
Measles	76 (76%)	62 (61%)
Fully vaccinated (against five diseases)	70 (70%)	51 (51%)
Fully vaccinated (against six diseases)	65 (65%)	42 (42%)

Measles vaccine coverage was 68% (101 of 149 children 12-23 months) if information from vaccine cards was supplemented with maternal recall.

G. Maternal and Newborn Care

Knowledge

Mothers of children 0-11 months (225) were asked about signs of danger after birth indicating the need for a woman to seek health care for herself. Of the 222 mothers who responded, ninety (40%) mentioned at least one of three danger signs (fever, excessive bleeding, or smelly vaginal discharge). Table 17 presents mothers' responses to the question.

Table 17: Mothers' knowledge of danger signs after birth indicating the need for a woman to seek health care for herself*

DANGER SIGN	NO. (%) OF MOTHERS
Fever	*48 (22%)*
Excessive bleeding	*25 (11%)*
Smelly vaginal discharge	*26 (12%)*

** Multiple responses were allowed.*

Mothers of children 0-11 months were also asked about danger signs among newborns indicating the need to seek immediate medical attention. Eighty-six mothers (38%) mentioned two or more signs. Table 18 lists the signs mentioned by mothers.

Table 18: Mothers' knowledge of danger signs among newborns indicating the need to seek immediate medical attention*

DANGER SIGN	NO. (%) OF MOTHERS
Fever	*135 (60%)*
Dehydration	*45 (20%)*
Vomiting	*31 (14%)*
Redness around the cord	*20 (9%)*
Convulsions	*18 (8%)*
Poor feeding	*16 (7%)*
Fast breathing	*15 (7%)*
Red or discharging eye	*3 (1%)*
Not active	*2 (1%)*
Jaundice or skin discoloration	*2 (1%)*

** Multiple responses were allowed.*

Coverage

1. Antenatal Care

Mothers of children 0-11 months (225) were asked if they sought antenatal care during their last pregnancy. Of the 222 mothers who responded, 192 did so in the affirmative (86%) and said they sought care from a doctor, nurse, or midwife. Table 19 presents information about provider of care for 192 mothers.

Table 19: Source of antenatal care during last pregnancy*

CARE PROVIDER	NO. (%) OF MOTHERS
Doctor	*150 (78%)*
Nurse/midwife	*39 (20%)*

Auxiliary midwife	*6 (3%)*
Community health worker	*4 (2%)*

** The sum of numbers is greater than 192 and the sum of percentages exceeds 100% because multiple responses were allowed.*

Of the 190 mothers who responded to a question about the number of antenatal visits, 115 (60%) mothers said they had at least four antenatal visits. Table 20 provides a summary of the number of visits.

Table 20: Number of antenatal visits during last pregnancy*

NUMBER OF ANTENTAL VISITS	**No. (%) OF MOTHERS**
One	18 (10%)
Two	21 (11%)
Three	35 (19%)
Four	21 (11%)
Five	16 (8%)
Six	14 (7%)
Seven	14 (7%)
Eight or more	50 (26%)

** One mother said "zero" in response to the question about the number of antenatal visits.*

Nine of 225 mothers said they received at least 90 days of iron and folate in their last pregnancy (4%).

2. Tetanus Toxoid Injections

Of 225 mothers of children 0-11 months 43 reported that they received at least two tetanus toxoid injections before the birth of their youngest child (19%).

3. HIV Testing

Mothers of children 0-11 months (225) were asked if they were tested for HIV during their antenatal visits. Seventy-seven said they were tested and know their serological status (34%).

4. Delivery and Postpartum Care

Ninety-eight of 225 mothers of children 0-11 months (44%) reported that the birth of their youngest child was attended by skilled health personnel. One hundred and four said a traditional birth attendant assisted them during the delivery (46%). Thirty-six reported that they and their newborn child received care in the first week after delivery from a skilled health care provider (16%).

H. Management of Childhood Illness

Knowledge

Forty-seven of 149 mothers with children 12-23 months knew at least two signs of childhood illness that indicate the need for treatment (32%).

Practice

Of 374 children 0-23 months, 297 were reported to have been ill in the two weeks prior to the survey (79%). Thirty-eight of these children received increased fluids and maintained feeding during the illness (13%).

I. Sources of Health Information

Table 21 presents the sources of health messages reported by mothers of children 12-23 months (149). The most common sources were radio and television.

Table 21: Sources of health messages

SOURCE OF HEALTH MESSAGES	% OF MOTHERS/CAREGIVERS
Radio	77 (52%)
Television	48 (32%)
Community Health Worker	42 (28%)
Newspaper	30 (20%)
Member of basic organization (health educator)	27 (18%)

** The sum of numbers is greater than 149 and the sum of percentages exceeds 100% because multiple responses were allowed.*

ANNEXES

Annexure 1: Additional Results (Supplementary Data Analysis)

Using the FANTA Household Dietary Diversity Index (HDDI) three groups were formed based on the number of food types consumed in the household the day prior to the survey as follows:

Classification	Number of food groups consumed	Number	%
Group 1	0-5 (mean =4)	114	30%
Group 2	5-7 (mean=6)	126	34%
Group 3	7-12 (mean=9)	134	36%
Total		374	

Table A1: Child survival project indicator values for household dietary diversity score groups

INDICATOR	Indicator value (%)		
	HDDS Group 1 (lowest score)	HDDS Group 2	HDDS Group 3 (highest score)
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	34	41	73
Proportion of mothers of children age 0–11 months whose last delivery was attended by a traditional birth attendant	48	40	51
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	25	30	45
Proportion of mothers of children age 12–23 months who demonstrate an accepting attitude toward people living with HIV/AIDS	8	8	13
Proportion of mothers of children age 12–23 months who purify drinking water	30	25	43
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	51	36	60
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution and zinc	3	0	3
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	49	41	60
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	72	60	73
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	71	63	66
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in	15	0	17

INDICATOR	Indicator value (%)		
	HDDS Group 1 (lowest score)	HDDS Group 2	HDDS Group 3 (highest score)
the past two weeks			
Proportion of mothers with a child 12-23 months who know at least three symptoms of pneumonia	0	0	2
Proportion of children age 12–23 months who have received the DPT1 vaccine	80	89	85
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	22	13	16
Proportion of mothers of children age 0–11 months who received at least 90 days of iron and folate in last pregnancy	3	4	6
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	13	13	21

Note: % = Percent, HDDS = Household dietary diversity score.

Table A2: Rapid CATCH findings for household dietary diversity score groups

INDICATOR	Indicator value (%)		
	HDDS Group 1 (lowest score)	HDDS Group 2	HDDS Group 3 (highest score)
Proportion of children age 0-23 months who were born at least 24 months after the previous surviving child	70	76	63
Proportion of children age 0-11 months whose births were attended by skilled health personnel	39	48	44
Proportion of mothers with children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	9	22	25
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	20	29	36
Proportion of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	51	52	53
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	39	56	55
Proportion of children age 12–23 months who received a measles vaccine	54	64	65
Proportion of children age 12–23 months who slept under an insecticide-treated net the previous night	1	4	4
Mothers with children age 12–23 months who cite at least two known ways of reducing the risk of HIV infection	92	88	87
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	3	3	3
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	43	26	28
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	17	7	15

Note: % = Percent, HDDS = Household dietary diversity score.

Table A3: DPT Vaccine Coverage by Child's Gender

INDICATOR	Female			Male		
	Num	Den	%	Num	Den	%
Proportion of children age 12–23 months who have received the DPT1 vaccine	47	53	89	39	48	80
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	8	47	17	7	39	18

Note: Num = Numerator, Den = Denominator, % = Percent.

Table A4: Place where delivery of youngest child took place*

PLACE	*NO. (%) OF MOTHERS*
Home	*131 (59%)*
Hospital	*90 (40.5%)*
Clinic	*1 (0.5%)*

* Of the 225 mothers of children 0-11 months who were asked the question, three did not respond.

Table A5: Postnatal care received by mother within a week after birth of youngest child

CARE	No. (%) OF MOTHERS
Received	47 (21%)
Not received	178 (79%)
Total	225

Table A6: First source of care for child's illness

SOURCE	No. (%) OF CHILDREN
Health center	76 (37%)
Hospital	62 (30%)
Friend or relative	19 (10%)
Private clinic	17 (8%)
Pharmacy	11 (6%)
Midwife	1 (0.6%)
Quack	1 (0.6%)
Houngan	1 (0.6%)
Traditional healer	1 (0.6%)
Other non-formal source	14 (7%)
Total	203*

** Of the 297 children who experienced an illness, advice or treatment was sought for 203.*

Table A7: Second source of care for child's illness

1.1.a.i.1 SOURCE	**No. (%) OF CHILDREN**
Health center	17 (41%)
Hospital	13 (31%)
Private clinic	4 (9%)
Traditional healer	4 (9%)
Friend or relative	2 (4%)
Houngan	1 (3%)
Other non-formal source	1 (3%)
Total	42*

** Of the 203 children for whom the first source of care was identified, a second source was identified for 42.*

Annexure 2: Questionnaires in English

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CHILDREN 0 - 11 MONTHS

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CONCERN, FOCAS, AND GRET
WITH MINISTRY OF HEALTH, REPUBLIC OF HAITI
URBAN HEALTH, PORT-AU-PRINCE
RAPID KNOWLEDGE, PRACTICES, AND COVERAGE (KPC) SURVEY

VERSION 04 MARCH 2006

Project site ☐ Senmaten - 1, Site Okay - 2, Dekayet - 3, Jalouzi/Bwa Mokèt - 4

Supervision zone ☐

Sampling area number ☐☐☐

Household number ☐☐☐

Description of house _____

Record number ☐☐

Name of interviewer _____

Name of supervisor _____

Verified by _____.
Supervisor

Interview date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Rescheduled ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Mother's name _____ Name _____ Surname

Mother's age ☐☐ years

Name of youngest child _____ Name _____ Surname

Gender Female ☐ Male ☐

Date of birth ☐☐ ☐☐ ☐☐☐☐ ASK FOR vaccination card or other card
Day Month Year

Age of child ☐☐ months

CONSENT FORM

Good morning/Good afternoon. My name is _____, and I am working with _____). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help _____and the Ministry of Health to plan health services and assess whether they are meeting their goals to improve children's health. The survey usually takes **30** minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask anything about the survey ?

Signature of interviewer: _____

Date: _____

RESPONDENT AGREES TO BE INTERVIEWED RESPONDENT DOES NOT AGREE TO BE INTERVIEWED

RESPONDENT BACKGROUND INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1.	How long have you lived in this area?	Years ☐☐ Month ☐☐	
2.	Who is the head of this household?	MOTHER (RESPONDENT).... 1 HUSBAND / PARTNER ..... 2 OTHER _____ 8 (SPECIFY)	
3	How many children living in this household are under five years of age?	☐ Children	If only one child →**7**
4.	What is the date of birth of your own child older than (NAME)?	☐☐ ☐☐ ☐☐☐☐ Day Month Year	
5.	Name?	Name_____ Surname_____	
6	Gender	Female ☐ Male ☐	
7	Have you attended school?	No……1 Yes……2	→**9**
8.	What was the highest grade you completed? CONVERT GRADE TO NUMBER OF YEARS.	☐☐ years	
9	Do you work? IF YES, What kind of work do you do? IF NO, CIRCLE « NO WORK ».	NO WORK.....1 HANDICRAFTS.....2 HARVESTING .....3 SELLING FOODS .....4 SHOP KEEPER/STREET VENDOR .....5 SERVANT/HOUSEHOLD WORKER.....6 SALARIED WORKER.....7 OTHER _____ 8 (SPECIFY)	→**11**
10	Who takes care of (NAME) when you are away?	Mother (RESPONDENT)..... A HUSBAND/PARTNER ..... B GRANDMOTHER .....C NEIGHBOR/FRIENDS…….E MAID/SERVANT ..... F OTHER _____ x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	Where do you usually prepare food?	Inside living area of home…… 1 Separate room in the house..... 2 Outside but near door of house.. 3 Outside, away from house.....4 Other _____ .....8 (SPECIFY)	
12	What is the primary cooking fuel used in the house?	Wood.....1 Charcoal .....2 Alcohol ……..3 Kerosene .....4 Electricity .....5 Gas .....6 Other _____ .8 (SPECIFY)	
13	Do you usually have smoke in the house while cooking?	NO ……1 YES……2 DON'T KNOW……...9	
14	Now I would like to ask you about the food that you and members of your family ate yesterday. READ ALL OF THE FOLLOWING CATEGORIES: a. Rice, bread, spaghetti, gruel, corn, corn flakes, biscuits? b. Potatoes, sweet potatoes, manioc? c. Vegetables? d. Fruit? e. Beaf, pork, or other meat? f. Eggs? g. Fish, crab (sea food) h. Nuts? i. Cheese, milk, or milk products? j. Food with oil, butter, or lard? k. Sugar or honey? l. Tea or coffee?	**NO** **YES** 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	

PRENATAL CARE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
15	Did you see anyone for prenatal care while you were pregnant with (NAME) ? IF YES: Whom did you see? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	**HEALTH PROFESSIONAL** DOCTOR .....A NURSE/MIDWIFE……B AUxILIARY/MIDWIFE .....C **OTHER PERSON** TRADITIONAL BIRTH ATTENDANT ..... D COMMUNITY HEALTH AGENT..... E OTHER _____ x (SPECIFY) NO ONE Z	→**24**
16	How many times did you see someone for care during the pregnancy?	NUMBER OF TIMES.....☐☐	
17	Do you have a maternal health card for your pregnancy with (NAME)? IF YES: Can I see the card?	YES, SEEN……1 NOT AVAILABLE .....2 NEVER HAD A CARD.....3	→**20** →**20**
18.	LOOK AT THE CARD AND RECORD THE NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF VISITS ☐☐	
19.	LOOK AT THE CARD AND RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD.	DAY MONTH YEAR First ☐☐ ☐☐ ☐☐☐☐ Second ☐☐ ☐☐ ☐☐☐☐ Third ☐☐ ☐☐ ☐☐☐☐ Fourth ☐☐ ☐☐ ☐☐☐☐	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
20	During any of the antenatal visits during your pregnancy with (NAME), did anyone talk to you about: READ ALL OF THE FOLLOWING: a) Babies getting the AIDS virus from their mothers? b) Things you can do to avoid getting the AIDS virus? c) Getting tested for the AIDS virus?	**No Yes Don't know** a) …… 1 2 9 b) ……. 1 2 9 c) …… 1 2 9	
21	I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care ?	NO ……1 YES ……..……2	→**24**
22	Where was the test done?	**NOTE THE PLACE HERE** _____ (SPECIFY THE PLACE)	
23	Remember, I don't want to know the results, but did you get the results of the test ?	NO ……1 YES ……2	
24	Before you gave birth to (NAME), did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth ?	NO .....1 YES.....2 DON'T KNOW..... 9	
25	When you were pregnant with (NAME), did you receive or buy any iron and folic acid tablets or syrup? SHOW SYRUP.	NO .....1 YES.....2 DON'T KNOW.....9	→**27** →**27**
26	How many days did you take the tablets or syrup? IF THE ANSWER IS IN WEEKS OR MONTHS, CALCULATE THE NUMBER OF DAYS.	NUMBER OF DAYS ☐☐☐ DON'T KNOW.....999	
27	What are the symptoms during pregnancy indicating the need to seek health care ? RECORD ALL MENTIONED.	FEVER.....…….A SHORTNESS OF BREATH ..... …. B VAGINAL BLEEDING…….. C HEADACHE ……. D SWELLING OF THE BODY/HANDS/FACE…. E OTHER_____ x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		DON'T KNOW ..... …Z	→29
28	Which is the first place you would go for care if you had these symptoms?	Hospital …….. ……..1 Health center…… ……..2 Private clinic …… 3 Nurse …….. 4 Auxiliary nurse …….. 5 Trained traditional birth attendant…… 6 Untrained traditional birth attendant ……7 OTHER _____... ….....8 (SPECIFY) DON'T KNOW ……..9	

1.2

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
29.	When can the AIDS virus be transmitted from a mother to her baby? READ ALL OF THE FOLLOWING: a) During pregnancy? b) During delivery? c) Through breastfeeding?	**No Yes Don't know** a) During pregnancy . … . 1 2 9 b) During delivery ……. .1 2 9 c) Through breastfeeding … 1 2 9	
30	If a mother knows that she is HIV-positive, should she breastfeed her baby?	NO ……1 YES ……..……..2 DON'T KNOW ……..…….9	
31	If a mother is unsure whether or not she is HIV-positive, should she breastfeed her baby?	NO ……1 YES ……..……..2 DON'T KNOW ……..…….9	

1.3

DELIVERY AND POSTPARTUM CARE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
32	Where did you deliver (NAME)?	**HOME** YOUR HOME……..……..1 OTHER HOME ……...……..2 **HEALTH FACILITY**	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		Hospital …….. ……3 Health Center ……. ……..4 OTHER_____ 8 (SPECIFY)	→34 If she delivered at a health facility go to Q. 34
33	Why do women give birth at home? RECORD ALL MENTIONED.	Hospitals are too expensive.....A No problem to deliver at home.....B Not received well at hospital ..... …. D Hospital too far.....…E Have to take care of children at home … .....F Lack of transportation ..... G Hospital delivery may be caeserian.....H Lack of doctor/midwife at hospital..... I Poor quality of care at hospital….....J OTHER..... x (SPECIFY)	
34	Who assisted you with (NAME'S) delivery? RECORD ALL MENTIONED.	**HEALTH PROFESSIONAL** DOCTOR.....A NURSE/MIDWIFE .....B AUxILIARY/MIDWIFE .....C **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT ……D UNTRAINED TRADITIONAL BIRTH ATTENDANT ….. .. …E (Name_____) HEALTH AGENT.....…… …F FAMILY MEMBER_____.... …G (SPECIFY) 1.3.a.i.1.1 OTHER_____..... ……x (SPECIFY) NO ONE……..Z	
35.	Was a clean birth kit used?	NO ..... ….....1 YES.....2 DON'T KNOW..... 9	
36.	What instrument was used to cut the cord?	NEW RAZOR BLADE .....1 OTHER INSTRUMENT 2	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
37	Who cut the cord?	**HEALTH PROFESSIONAL** DOCTOR.....1 NURSE/MIDWIFE .....2 AUxILIARY/MIDWIFE .....3 **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT .....4 UNTRAINED TRADITIONAL BIRTH ATTENDANT ....5 (Name_____) HEALTH AGENT..... …6 FAMILY MEMBER_____.... …7 (SPECIFY) 1.3.a.i.1.2 OTHER_____..... .....8 (SPECIFY) NO ONE.....9	
38.	What was put on the stump after cutting the cord?	OIL .....1 CLOTH .....2 DETERGENT/SOAP .....3 TALCUM POWDER .....4 ANTIBIOTIC/ANTISEPTIC.....5 ALCOHOL.....6 NOTHING .....7 OTHER _____ .....8 (SPECIFY) DON'T KNOW 9	
39.	Was (NAME) weighed at birth?	YES.....1 NO ..... 2 DON'T KNOW.....9	
40.	After (NAME'S) birth, did anyone check on your health?	NO .....1 YES.....2	→**46**
41	How many days after the delivery did the first check take place? RECORD <<00>> DAYS, IF SAME DAY.	DAYS AFTER DELIVERY WEEKS AFTER DELIVERY DON'T KNOW 99	
42	Who checked on your health at that time? PROBE FOR THE MOST QUALIFIED PERSON.	**HEALTH PROFESSIONAL** DOCTOR.....1 NURSE/MIDWIFE .....2 AUxILIARY/MIDWIFE .....3 **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT .....4 UNTRAINED TRADITIONAL BIRTH ATTENDANT ....5 (Name_____) HEALTH AGENT..... …6	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		FAMILY MEMBER_____.... ...7 (SPECIFY) 1.3.a.i.1.3 OTHER_____..... .....8 (SPECIFY) NO ONE……..9	
43	What did they check?	Nothing ……..……...A Bleeding .....……B Fever..... …… C Vaginal discharge.....D Blood pressure.....E OTHER_____ .....x (SPECIFY)	
44	What did they do for (NAME)?	Nothing ……A Asked about breastfeeding..... …B Checked cord.....……C Gave vaccine..……E Checked breathing……F OTHER_____.....x (SPECIFY)	
45	During your postpartum check, were you counseled on the following? NOTE ADVICE GIVEN BY ANYBODY. READ ALL OF THE FOLLOWING: Child spacing Infant nutrition Childhood immunizations Diarrhea among children Danger signs of infant illness	**No Yes** Child spacing 1 2 Infant nutrition 1 2 Childhood immunizations 1 2 Diarrhea among children 1 2 Danger signs of infant illness 1 2	
46	In the first two months after delivery, did you receive a vitamin A dose like this ? SHOW VITAMIN A.	NO.....……1 YES.....2 DON'T KNOW ……9	
47	What are the signs of danger after giving birth indicating the need for you to seek health care ? RECORD ALL MENTIONED.	FEVER.....A ExCESSIVE BLEEDING .....B SMELLY VAGINAL DISCHARGE……C OTHER_____.. x (SPECIFY) DON'T KNOW.....Z	
48	What are the signs to watch for	Poor appetite ……A	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	that may indicate that a newborn baby is ill and needs to be taken to hospital without delay? RECORD ALL MENTIONED.	Not breastfeeding ……B Fever ……C Vomiting ……D Convulsions ……E Fast breathing……F Not active ……G Redness around the cord ……H Red/discharging eye ……I Jaundice/skin discoloration ……J Dehydration ……K OTHER_____ x (SPECIFY) DON'T KNOW……Z	

1.4

BREASTFEEDING AND CHILD NUTRITION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
49	Did you ever breastfeed (NAME)?	NEVER ……1 YES…… 2	→55
50	How long after birth did you first put (NAME) to the breast ?	IMMEDIATELY/WITHIN FIRST HOUR ……1 AFTER FIRST HOUR BUT WITHIN FIRST DAY ……2 SECOND DAY OR LATER……3 DON'T REMEMBER……9	
51	Did you give (NAME) colostrum after birth? COLOSTRUM (FIRST MILK) IS THE LIQUID THAT COMES FROM BREASTS AFTER DELIVERY.	YES…… 1 NO …… 2 DON'T KNOW…… 9	
52	Did you give (NAME) sugar and water or a liquid like LÒK after birth?	YES…… 1 NO …… 2 DON'T KNOW…… 9	
53	Are you currently breastfeeding (NAME)?	YES…… 1 NO …… 2 DON'T KNOW…… 9	→55
54	For how long did you breastfeed (NAME)? IF LESS THAN ONE MONTH, RECORD « 00 ».	☐☐ MONTHS	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
55	Did (NAME) drink anything from a bottle (or other object) with a nipple yesterday or last night?	NO ..... 1 YES ……..……2	
56	Now I would like to ask you about the types of liquids (NAME) drank yesterday during the day and night. Did (NAME) drink any of the following liquids yesterday during the day or night? READ THE LIST OF LIQUIDS. MOTHER'S MILK WITH WATER WATER SWEET WATER FRUIT JUICE MILK POWDER TEA/INFUSIONS HONEY BREASTMILK	MOTHER'S MILK WITH WATER ….A WATER ……B SWEET WATER..... ....C FRUIT JUICE…… D MILK POWDER……E TEA/INFUSIONS……..F HONEY ..... G BREASTMILK……..……H OTHER_____x (SPECIFY)	
56a	Are you giving (NAME) any solid, semi-solid, or soft foods other than liquids ?	NO ..... 1 YES……..……2	→57
56b	How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day and at night ?	NUMBER OF TIMES..... ☐☐ DON'T KNOW..... .9	
57	Did (NAME) receive a Vitamin A dose like this during the last six months? SHOW CAPSULE.	NO ..... 1 YES..... 2 DON'T KNOW ……..9	

1.5

SICK CHILD

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
58	Did (NAME) experience any of the following in the past two weeks? READ ALL OF THE FOLLOWING:	DIARRHEA.....A BLOOD IN STOOL ..... B COUGH .....C DIFFICULT BREATHING……...D	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Diarrhea? Blood in stool? Cough? Difficult breathing? Fast breathing or short, quick breaths? Fever? Malaria? Convulsions?	FAST BREATHING/SHORT, QUICK BREATHS..... E FEVER……..F MALARIA..... G CONVULSIONS ..... H OTHER_____.....x NONE ……Z	→ END
59	Did you seek advice or treatment for (NAME)?	NO ……..1 YES … ……2	→ 65
60	How long after you noticed (NAME'S) symptoms did you seek treatment?	SAME DAY.....0 NExT DAY.....1 TWO DAYS .....2 THREE DAYS OR MORE…..3	
61	Where did you first go for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……..11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
62	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED.	RESPONDENT HERSELF .... A HUSBAND/PARTNER ..... B GRANDMOTHER .....C RESPONDENT'S MOTHER-IN-LAW ...D FRIEND / NEIGHBOR..... E OTHER_____..... x (SPECIFY)	
63	Did you go anywhere else for advice or treatment for (NAME)?	NO 1	→ 65

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		YES.....2	
64	Where did you go next for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center……. ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……..11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
65	During (NAME'S) illness, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS .....1 SAME .....2 MORE.....3 CHILD NOT BREASTFED ….4 DON'T KNOW.....9	
66	During (NAME'S) illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	
67	During (NAME'S) illness, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO EAT.....4 DON'T KNOW.....9	
68	During the period when (NAME) was recovering from illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	
69	**REFER BACK TO QUESTION 58 AND LOOK AT THE MOTHER'S RESPONSES.**	**CHECK WHICH MODULES APPLY**	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	IF **A OR B:** ADMINISTER **DIARRHEA MODULE**	MODULE C (DIARRHEA)	→ **72**
	IF **C, D, OR E:** ADMINISTER **RESPIRATORY PROBLEM MODULE**	MODULE A (RESPIRATORY PROBLEM)	→ **70**
	IF **F, G, OR H:** ADMINISTER **MALARIA MODULE**	MODULE B (MALARIA)	→ **71**
MODULE A : TREATMENT FOR CHILD'S RESPIRATORY PROBLEM			
70	Which medicines were given to (NAME) for the respiratory problem? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING.....A ASPIRIN.....B ACETAMINOPHEN..... C AMOxICILLIN..... D ERYTHROMYCIN.....E AMPICILLIN .....F COTRIMOxAZOLE ……G DON'T KNOW ……. ……..Z OTHER _____ x (SPECIFY)	
MODULE B : TREATMENT FOR CHILD'S FEVER			
71	Which medicines were given to (NAME) for his/her fever? RECORD ALL MENTIONED. ASK MOTHER TO SHOW THE DRUG(S) TO YOU.	NOTHING……A ASPIRIN…… ……...B ACETAMINOPHEN ……..…..C COTRIMOxAZOLE… ……D CHLOROQUINE …… E QUININE ..... F DON'T KNOW ……..Z OTHER _____ x (SPECIFY)	
MODULE C : DIARRHEA CASE MANAGEMENT			
72	What was given to (NAME) to treat the diarrhea? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING..... A ORAL REHYDRATION SOLUTION .....B HOME-MADE FLUID .....C PILL OR SYRUP .....D INJECTION.....E INTRAVENOUS (IV) FLUIDS..... F HOME REMEDY/TRADITIONAL REMEDY……. G DON'T KNOW…… Z OTHER_____ x (SPECIFY)	
73	Was (NAME) given zinc for the diarrhea?	NO ……1 YES ……..……..2 IF YES, for how many days ? __ __	

END

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CHILDREN 12 – 23 MONTHS

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CONCERN, FOCAS, AND GRET
WITH MINISTRY OF HEALTH, REPUBLIC OF HAITI
URBAN HEALTH, PORT-AU-PRINCE
RAPID KNOWLEDGE, PRACTICES, AND COVERAGE (KPC) SURVEY

VERSION 04 MARCH 2006

Project site ☐ Senmaten - 1, Site Okay - 2, Dekayet - 3, Jalouzi/Bwa Mokèt - 4

Supervision zone ☐

Sampling area number ☐☐☐

Household number ☐☐☐

Description of house _____

Record number ☐☐

Name of interviewer _____

Name of supervisor _____

Verified by _____.
Supervisor

Interview date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Rescheduled ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Mother's name _____ Name _____ Surname

Mother's age ☐☐ years

Name of youngest child _____ Name _____ Surname

Gender Female ☐ Male ☐

Date of birth ☐☐ Day ☐☐ Month ☐☐☐☐ Year ASK FOR vaccination card or other card

Age of child ☐☐ months

CONSENT FORM

Good morning/Good afternoon. My name is _____, and I am working with _____). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help _____and the Ministry of Health to plan health services and assess whether they are meeting their goals to improve children's health. The survey usually takes **30** minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask anything about the survey ?

Signature of interviewer: _____

Date: _____

RESPONDENT AGREES TO BE INTERVIEWED RESPONDENT DOES NOT AGREE TO BE INTERVIEWED

RESPONDENT BACKGROUND INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1.	How long have you lived in this area?	Years ☐☐ Months ☐☐	
2.	Who is the head of this household?	MOTHER (RESPONDENT).... 1 HUSBAND / PARTNER ..... 2 OTHER _____ 8 (SPECIFY)	
3	How many children living in this household are under five years of age?	☐ Children	If only one child →**7**
4.	What is the date of birth of your own child older than (NAME)?	☐☐ ☐☐ ☐☐☐☐ Day Month Year	
5.	Name?	Name_____ Surname_____	
6	Gender	Female ☐ Male ☐	
7	Have you attended school?	No……1 Yes……2	→**9**
8.	What was the highest grade you completed? CONVERT GRADE TO NUMBER OF YEARS.	☐☐ years	
9	Do you work? IF YES, What kind of work do you do? IF NO, CIRCLE « NO WORK ».	NO WORK.....1 HANDICRAFTS.....2 HARVESTING .....3 SELLING FOODS .....4 SHOP KEEPER/STREET VENDOR .....5 SERVANT/HOUSEHOLD WORKER.....6 SALARIED WORKER.....7 OTHER _____ 8 (SPECIFY)	→**11**
10	Who takes care of (NAME) when you are away?	Mother (RESPONDENT).....A HUSBAND/PARTNER ..... B GRANDMOTHER ..... C NEIGHBOR/FRIENDS…….E MAID/SERVANT .....F OTHER _____ x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	Where do you usually prepare food?	Inside living area of home……. 1 Separate room in the house..... 2 Outside but near door of house.. 3 Outside, away from house.....4 Other_____.....8 (SPECIFY)	
12	What is the primary cooking fuel used in the house?	Wood ..... 1 Charcoal ..... 2 Alcohol ……..3 Kerosene ..... 4 Electricity ..... 5 Gas ..... 6 Other _____. 8 (SPECIFY)	
13	Do you usually have smoke in the house while cooking?	NO ……1 YES……2 DON'T KNOW……...9	
14	Now I would like to ask you about the food that you and members of your family ate yesterday. READ ALL OF THE FOLLOWING CATEGORIES: a. Rice, bread, spaghetti, gruel, corn, corn flakes, biscuits? b. Potatoes, sweet potatoes, manioc? c. Vegetables? d. Fruit? e. Beaf, pork, or other meat? f. Eggs? g. Fish, crab (sea food) h. Nuts? i. Cheese, milk, or milk products? j. Food with oil, butter, or lard? k. Sugar or honey? l. Tea or coffee?	**NO** **YES** 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	

WATER AND SANITATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
74	I would like to ask you some questions about water supply and toilet facilities. What is the main source of drinking water for members of your household?	FREE PUBLIC WATER SUPPLY.....1 PAID WATER SUPPLY.....2 WATER SUPPLY IN HOUSE.....3 CISTERN .....4 RIVER .....5 SPRING .....6 WELL .....7 RAIN WATER .....8 LÒT _____x (SPECIFY)	
75	Do you treat your water in any way to make it safer for drinking?	NO .....1 YES 2	→**78**
76	What do you usually do to the water to make it safer to drink? CIRCLE MORE THAN ONE RESPONSE ONLY IF SEVERAL METHODS ARE USUALLY USED TOGETHER.	SEDIMENTATION .....A STRAIN WATER THROUGH CLOTH...B BOIL WATER .....C ADD BLEACH OR CHLORINE.....D FILTER.....E SOLAR DISINFECTION .....F OTHER _____x (SPECIFY) DON'T KNOW.....Z	→**78**
77	When did you treat your water the last time using this method?	TODAY.....1 YESTERDAY.....2 OVER ONE DAY AGO BUT LESS THAN ONE WEEK.....3 ONE WEEK AGO OR MORE BUT LESS THAN A MONTH.....4 ONE MONTH AGO OR MORE.....5 DON'T REMEMBER.....9	
78	What kind of toilet is used by the household? IF MOTHER SAYS "PUBLIC LATRINE", ASK ABOUT THE TYPE, CIRCLE 2 FOR QUESTION 79 AND GO TO QUESTION 80.	NO TOILET/NATURE.....1 FLUSH LATRINE.....2 OTHER LATRINE.....3 PIT.....4 VENTILATED PIT..... 5 OTHER_____.....8 (SPECIFY)	→**80**
79	Do you share this toilet with other households ?	NO.....1 YES.....2	
80	What do you do with the stools of babies or young children who can't go by themselves?	THROWN IN LATRINE..... .....1 BURIED IN THE YARD .....2 NOT DISPOSED/LEFT ON GROUND ....3 OTHER_____.....8 (SPECIFY)	
81	What do you do with your garbage?	THROWN IN OPEN PIT.....1 PUT IN CLOSED PIT .....2 PUT ANYWHERE .....3 BURNED .....4 GARBAGE COLLECTION SERVICE.....5 OTHER _____ 8 (SPECIFY)	

CHILD IMMUNIZATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
82	Do you have a card where (NAME'S) vaccinations are written down? IF YES, May I see it?	YES, SEEN BY INTERVIEWER ….. 1 NOT AVAILABLE/LOST/MISPLACED… 2 NEVER HAD A CARD…… 3 NEVER HAD VACCINE..... 4 DON'T KNOW.....9	 →**86** →**86** →**88** →**86**
83	WRITE DOWN THE VACCINATION DATE FOR EACH VACCINE FROM THE CARD.	WRITE «11/11/1111» IF THE CARD SHOWS THAT A VACCINATION WAS GIVEN BUT NO DATE IS RECORDED **DAY MONTH YEAR**	
	a. BCG	BCG...	
	b. POLIO 0 (POLIO GIVEN AT BIRTH)	P0	
	c. POLIO 1	P1	
	d. POLIO 2	P2	
	e. POLIO 3	P3	
	f. DPT 1	DPT 1…	
	g. DPT 2	DPT 2…	
	h. DPT 3	DPT 3…	
	i. MEASLES	MEASLES…	
	j. VITAMIN A (MOST RECENT)	VIT. A...	
84	CHECK THE CARD OF (NAME) TO SEE IF THE CHILD HAS BEEN WEIGHED IN THE LAST FOUR MONTHS.	NO ..... 1 YES..... 2 NO PLACE IN CARD FOR RECORDING WEIGHT…9	
85	Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations received during a national immunization day campaign?	NO .....1 YES.....2 DON'T KNOW ……9	→**88** →**87** →**88**
86	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received during a national immunization day campaign?	NO .....1 YES.....2 DON'T KNOW ……9	→**88** →**87** →**88**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
87	Please tell me if (NAME) received any of the following vaccinations:		
87a	BCG vaccine against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	NO .....1 YES.....2 DON'T KNOW.....9	
87b	Polio vaccine, that is, drop in mouth?	NO .....1 YES.....2 DON'T KNOW.....9	→**87e** →**87e**
87c	When was the first dose of polio vaccine received?	JUST AFTER BIRTH..... 1 LATER 2	
87d	How many times was the polio vaccine received?	NUMBER OF TIMES… ☐☐	
87e	DPT vaccine, that is, an injection given in thigh or buttocks, sometimes given at same time as polio drops?	NO .....1 YES.....2 DON'T KNOW.....9	→**87g** →**87g**
87f	How many times?	NUMBER OF TIMES… ☐☐	
87g	An injection to prevent measles?	NO .....1 YES.....2 DON'T KNOW.....9	
88	Did (NAME) receive a vitamin A dose like this during the last four months? SHOW CAPSULE.	NO .....1 YES.....2 DON'T KNOW.....9	

MOSQUITO BEDNET USE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
89	Do you have a mosquito net?	NO ……1 YES……..2	→**92**
90	Has the bednet ever been treated with insecticide?	NO.....1 YES.....2 DON'T KNOW.....9	
91	Did (NAME) sleep under the mosquito net last night?	NO ……1 YES……..2	

CHILDHOOD ILLNESS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
92	What are the signs and symptoms of illness in a child indicating the need for treatment? RECORD ALL MENTIONED.	Not eating/drinking/breastfeeding ..... A Looks unwell/Not playing normally ..... B Fast or difficult breathing ..... C High fever ..... D Unable to sit up unassisted ..... E Vomiting ..... F Lethargic / Unconscious ..... G Convulsions ..... H OTHER_____ ..... x (SPECIFY) DON'T KNOW..... Z	
93	What are the symptoms of pneumonia in a child? RECORD ALL MENTIONED.	Convulsions ..... A Fast breathing ..... B Difficult breathing ..... C Chest indrawing ..... D Fever..... E OTHER _____ ..... x (SPECIFY) DON'T KNOW..... Z	
94	What are the signs and symptoms that would cause you to seek advice or treatment for diarrhea for your child? RECORD ALL MENTIONED.	Diarrhea lasting three days or more..... A Blood in stools ..... B Dehydration / Dry lips ..... C Sunken fontanelle ..... D Decreased urine ..... E Fever ..... F Loss of appetite ..... G Sunken eye ..... H Restless / Irritable ..... I Floppiness ..... J OTHER _____ ..... x (SPECIFY) DON'T KNOW..... Z	
95	What causes malarial fever? RECORD ALL MENTIONED.	MOSQUITO BITES ..... A SORCERY ..... B INJECTION OF DRUGS ..... C BLOOD TRANSFUSION ..... D INJECTION ..... E SHARING OF BLADES ..... F OTHER _____ x (SPECIFY) DON'T KNOW ..... Z	
96	Have you heard of oral rehydration solution? IF YES, ASK MOTHER TO DESCRIBE PREPARATION OF THE SOLUTION. IF NO, CIRCLE 3 (NEVER HEARD OF ORAL REHYDRATION SOLUTION). AFTER MOTHER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE DESCRIBED SOLUTION PREPARATION CORRECTLY OR INCORRECTLY. CIRCLE 1 (CORRECTLY) IF MOTHER HAS MENTIONED THE FOLLOWING: • USE ONE LITER OF CLEAN WATER (1 LITER = 3 BOTTLES OF COLA) • USE ENTIRE PACKET • DISSOLVE POWDER FULLY	YES ( ) NO ( ) DESCRIBED CORRECTLY ..... 1 DESCRIBED INCORRECTLY ..... 2 NEVER HEARD OF ORAL REHYDRATION SOLUTION..3	→98
97	Where can you find oral rehydration solution? RECORD ALL MENTIONED.	Street seller..... A Shop..... B Pharmacy..... C Community distributor ..... D Friends / Family ..... E Health center..... F OTHER_____ x (SPECIFY) DON'T KNOW ..... Z	

CHILD SPACING

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
98	Are you currently pregnant?	NO ..... 1 YES ..... 2 UNSURE 8	 → **101**
99	Do you want to have another child within the next two years?	NO ..... 1 YES ..... 2 UNSURE 8	→ **100** → **101** → **100**
100	Are you currently doing something or using a method to delay or avoid pregnancy? IF NO, CIRCLE «01» 'NO METHOD' IF YES, ASK : « What is the main method you or your husband/partner are using now to avoid or delay pregnancy ?» CIRCLE THE APPROPRIATE RESPONSE.	NO METHOD ..... 01 NORPLANT ..... 02 INJECTIONS ..... 03 PILL ..... 04 INTRAUTERINE DEVICE ..... 05 BARRIER METHOD/DIAPHRAGM ..... 06 CONDOM ..... 07 FOAM/GEL ..... 08 TUBAL LIGATION ..... 09 VASECTOMY ..... 10 LACTATIONAL AMENORRHEA (EXCL. BREASTFDNG) 11 RHYTHM ..... 12 ABSTINENCE ..... 13 WITHDRAWAL ..... 14 OTHER_____ .....88 (SPECIFY)	

HIV/AIDS AND OTHER SExUALLY TRANSMITTED INFECTIONS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	Now I would like to talk about something else. Have you heard of an illness called AIDS?	NO ..... 1 YES 2	→ **111**
102	Can people get the AIDS virus by having just one partner who is not infected and who has no other partners?	NO ..... 1 YES ..... 2 DON'T KNOW ……9	
103	Can people get the AIDS virus by using a condom every time they have sex ?	NO ..... 1 YES ..... 2 DON'T KNOW ……9	
104	Can people get AIDS virus by sharing food with a person who has AIDS?	NO ..... 1 YES ..... 2 DON'T KNOW ……9	
105	Can people get the AIDS virus by abstaining from sexual intercourse?	NO ..... 1 YES ..... 2 DON'T KNOW ……9	
106	Would you buy food from a shopkeeper or vendor if you knew that the person had the AIDS virus ?	NO ..... 1 YES ..... 2 DON'T KNOW ……9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	If a member of your family got infected with the AIDS virus, would you want it to remain a secret or not ?	YES, REMAIN A SECRET ……..1 NO…….2 DON'T KNOW/NOT SURE/IT DEPENDS.....3	
108	If a member of your family became sick with the virus that causes AIDS, would you be willing to care for him or her in your own house ?	NO.....1 YES.....2 DON'T KNOW ……9	
109	Do you personally know someone who had been denied health services in the last twelve months because he/she is suspected to have the AIDS virus or has the AIDS virus ?	YES.. 1 ……1 2 NO…. 3 2 8 DO NOT KNOW ANYONE WITH HIV/AIDS……. 3 DON'T KNOW/NOT SURE.……9	
110	Do you agree or disagree with the following statement: People with AIDS virus should be blamed for bringing the disease into the community.	NO.....1 YES.....2 DON'T KNOW ……9	
111	CHECK QUESTION 101: ❑ [IF HAS HEARD ABOUT AIDS, ASK:] Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact? ❑ [IF HAS NOT HEARD ABOUT AIDS, ASK:] Have you heard about infections that can be transmitted through sexual contact?	NO.....1 YES.....2	→113

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
112	Please describe the symptoms of sexually transmitted infections in women. **[DO NOT READ OUT RESPONSES ALOUD.** **FOR EACH SYMPTOM, CIRCLE '1' IF NOT MENTIONED. CIRCLE '2' IF MENTIONED.]** a) ABDOMINAL PAIN b) GENITAL DISCHARGE 1 2 c) FOUL SMELLING DISCHARGE d) BURNING PAIN ON URINATION e) GENITAL ULCERS/SORE f) SWELLING IN GROIN AREA g) ITCHING 1 2 h) OTHER i) NO ANSWER	NON Y N a) ABDOMINAL PAIN 1 2 1 2 b) GENITAL DISCHARGE 1 2 1 2 c) FOUL SMELLING DISCHARGE 1 2 1 2 d) BURNING PAIN ON URINATION 1 2 e) GENITAL ULCERS/SORE 1 2 f) SWELLING IN GROIN AREA 1 2 g) ITCHING 1 2 1 2 h) OTHER _____ 1 2 i) NO ANSWER ……..9 1 2	WI

HEALTH CONTACTS AND SOURCES OF INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
113	During the last month, how often have you come in contact with each of the following : READ EACH CATEGORY AND ASK IF SHE CAME IN CONTACT WITH THE PERSON FREQUENTLY, SOMETIMES, OR NEVER.	FREQUENTLY (4 times or more)	SOMETIMES (1-3 times)	NEVER (0 times)	
	DOCTOR?	1	2	3	
	NURSE/MIDWIFE?	1	2	3	
	HEALTH AGENT?	1	2	3	
	MEMBER OF BASIC ORGANIZATION?	1	2	3	
	NUTRITIONIST?	1	2	3	
	TRAINED TRADITIONAL BIRTH ATTENDANT?	1	2	3	
	TRADITIONAL HEALER?	1	2	3	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
114	In the past month, did you receive any health messages from the following? (By which means?) READ EACH CATEGORY AND CIRCLE 1 OR 2. YOU MUST CIRCLE 1 OR 2 FOR EACH CATEGORY.	NO	YES	
	RADIO? (Station _____)	1	2	
	NEWSPAPER?	1	2	
	TELEVISION ?	1	2	
	MEMBER OF BASIC ORGANIZATION?	1	2	
	HEALTH AGENT?	1	2	
	OTHER (SPECIFY)_____)	1	2	

1.6

SICK CHILD

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
115	Did (NAME) experience any of the following in the past two weeks? READ ALL OF THE FOLLOWING: Diarrhea? Blood in stool? Cough? Difficult breathing? Fast breathing or short, quick breaths? Fever? Malaria? Convulsions?	DIARRHEA.....A BLOOD IN STOOL ..... B COUGH ..... C DIFFICULT BREATHING……...D FAST BREATHING/SHORT, QUICK BREATHS..... E FEVER……..F MALARIA ..... G CONVULSIONS ..... H OTHER_____.....x NONE ……Z	→131
116	Did you seek advice or treatment for (NAME)?	NO ……..1 YES … ……..2	→ 122
117	How long after you noticed (NAME'S) symptoms did you seek treatment?	SAME DAY.....0 NExT DAY.....1 TWO DAYS.....2 THREE DAYS OR MORE.... 3	
118	Where did you first go for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……...11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
119	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED.	RESPONDENT HERSELF .....A HUSBAND/PARTNER.....B GRANDMOTHER .....C RESPONDENT'S MOTHER-IN-LAW .....D FRIEND / NEIGHBOR.....E OTHER_____..... x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
120	Did you go anywhere else for advice or treatment for (NAME)?	NO .....1 YES.....2	→ 122
121	Where did you go next for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……..11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
122	During (NAME'S) illness, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS .....1 SAME .....2 MORE.....3 CHILD NOT BREASTFED ….4 DON'T KNOW.....9	
123	During (NAME'S) illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	
124	During (NAME'S) illness, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO EAT.....4 DON'T KNOW.....9	
125	During the period when (NAME) was recovering from illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS .....1 SAME .....2 MORE.....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
126	**REFER BACK TO QUESTION 115 AND LOOK AT THE MOTHER'S RESPONSES.**	**CHECK WHICH MODULES APPLY**	
	IF **A OR B:** ADMINISTER **DIARRHEA MODULE**	MODULE C (DIARRHEA)	→ **129**
	IF **C, D, OR E:** ADMINISTER **RESPIRATORY PROBLEM MODULE**	MODULE A (RESPIRATORY PROBLEM)	→ **127**
	IF **F, G, OR H:** ADMINISTER **MALARIA MODULE**	MODULE B (MALARIA)	→ **128**
MODULE A : TREATMENT FOR CHILD'S RESPIRATORY PROBLEM			
127	Which medicines were given to (NAME) for the respiratory problem? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING.....A ASPIRIN.....B ACETAMINOPHEN..... C AMOxICILLIN..... D ERYTHROMYCIN.....E AMPICILLIN .....F COTRIMOxAZOLE …….G OTHER _____ x (SPECIFY) DON'T KNOW ……. ……..Z	
MODULE B : TREATMENT FOR CHILD'S FEVER			
128	Which medicines were given to (NAME) for his/her fever? RECORD ALL MENTIONED. ASK MOTHER TO SHOW THE DRUG(S) TO YOU.	NOTHING……A ASPIRIN…… ……...B ACETAMINOPHEN ……..…..C COTRIMOxAZOLE… ……D CHLOROQUINE …… E QUININE ..... F OTHER _____ x (SPECIFY) DON'T KNOW ……..Z	
MODULE C : DIARRHEA CASE MANAGEMENT			
129	What was given to (NAME) to treat the diarrhea? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING..... A ORAL REHYDRATION SOLUTION ..... B HOME-MADE FLUID .....C PILL OR SYRUP .....D INJECTION.....E INTRAVENOUS (IV) FLUIDS..... F HOME REMEDY/TRADITIONAL REMEDY……. G OTHER_____ x (SPECIFY) DON'T KNOW…… Z	
130	Was (NAME) given zinc for the diarrhea?	NO ……1 YES ……..……2 IF YES, for how many days ? __ __	

ANTHROPOMETRY

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
131	Has (NAME) received a medicine against worms in the last six months?	NO ..... 1 YES..... 2 DON'T KNOW 9	
132	ASK MOTHER FOR PERMISSION TO MEASURE ARM CIRCUMFERENCE FOR (NAME). IF SHE AGREES, RECORD INFORMATION IN SPACE BELOW.		

ARM CIRCUMFERENCE

			mm

HAND WASHING

133	Does your household have a special place for hand washing?	NO.....1 YES.....2	→**END**
134	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF THE FOLLOWING ITEMS ARE PRESENT:	**NO YES** (A) WATER/TAP .....1 2 (B) SOAP/DETERGENT....1 2 (C) WASH BASIN.....1 2	
135	When do you wash your hands with soap? RECORD ALL MENTIONED.	NEVER ..... …….A BEFORE PREPARING FOOD ..... B BEFORE FEEDING/BREASTFEEDING ……C AFTER DEFECATION .....D LÈ W FIN N NETWAYE YON TIMOUN AFTER CLEANING A CHILD WHO HAS DEFECATED … E OTHER _____ 8 (SPECIFY)	

1.7 Annexure 3: Questionnaires in Kreyol

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TIMOUN 0 - 11 MWA

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CONCERN, FOCAS, AK GRET ANSANM AVEK MINISTE SANTE PIBLIK REPIBLIK DAYITI
SANTE IBEN NAN POTOPRENS
Ankèt Rapid sou Konesans, Pratik e Kouveti (KPK)

VÈSYON 04 MAS 2006

Zon pwoje a ☐ Senmaten - 1, Site Okay - 2,
Dekayet-3, Jalouzi/Bwa Mokèt-4

Zòn sipèvisyon-an ☐

Nimewo echantiyon nan blok la ☐☐☐

Nimewo kay nan echantiyon an ☐☐☐ (pami kantite kay ki nan bok la)

Deskripsyon kay la _____

Nimewo rejis ☐☐

Non enketè a _____

Non sipèvizè a _____ _____

Verifye pa _____.
Sipevizè a

Dat entèvyou a ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Ranvoye pou ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Non manman-an _____ _____
Non Siyati

Laj Manman -an ☐☐ an

Kouman w rele pitit ki pi piti a _____ _____
Non Siyati

Se yon Tifi ☐ Tigason ☐

Dat li te fèt ☐☐ ☐☐ ☐☐☐☐ MANDE KAT Vaksen ou lot kat.

Jou mwa ane

Laj timoun nan ☐☐ mwa

OTORIZASYON MOUN KI REPONN

Bonjou/Bonswa. M rele _____, e m ap travay pou _____). N ap fè yon enkèt, nou ta swete w patisipe ladan. M ta renmen poze w kèk kesyon sou sante w, epi tou sou sante pitit ou ki pi piti a, sa ki gen mwens pase dezan. Enfòmasyon sa yo pral sèvi _____ak Ministe sante piblik pou planifye sèvis sante l yo e pou l evalye si yo koresponn ak objektif li yo pou amelyore sante timoun nan. Ankèt la pran nòmalman **30** minit. Nenpòt enfòmasyon ou bay la, l ap rete sekrè, e pèsonn p ap konnen l.

Patisipasyon nan ankèt sa a li volontè, e ou ka deside pa reponn ak kèk kesyon pèsonèl oubyen nenpòt ki lòt kesyon. Men, nou swete ou patisipe nan ankèt sa a, piske sa ou panse a trè enpòtan.

Koulye a, èske ou gen kesyon pou poze m sou ankèt la ?

Siyati anketè a: _____

Dat: _____

ANKETE A AKSEPTE POU L ANKETE

ANKETE A PA AKSEPTE POU L ANKÈTE

PATI I: ENFOMASYON SOU MANMAN PITIT LA AK SITYASYON FANMI LI

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
1.	Depi konbyen tan ou rete nan katye sa a?	Ane ☐☐ Mwa ☐☐	
2.	Ki lès ki chèf kay la?	MANMAN (ANKETE)).....1 MARI / PATNÈ .....2 LÒT _____8 (PRESIZE)	
3	Konbyen timoun ki gen pi piti pase senk an kav viv nan kay la?	☐ Timoun	Si se yon sèl timoun, ale nan kesyon →**7**
4.	Ti moun ki vin avan-an. (non ti moun nan) la ki dat li fèt	☐☐ jou ☐☐ mwa ☐☐☐☐ ane	
5.	Kijan li rele	non_____ siyati _____	
6	Se yon	Tifi ☐ Ti gason ☐	
7	Eske 'w te ale lekol.	Non……1 Wi……2	→**9**
8.	Nan ki klas ou te rive ? KALKILE KONYEN ANE KLAS LI FÈ-A VO	☐☐ ane	
9	Eske w ap travay ? SI WI, Ki kalite travay w ap fè ? SI NON, ANSÈKLE « PA P TRAVAY »	PA P TRAVAY .....1 ATIZANA.....2 FÈ JADEN .....3 VANN MANJE .....4 KOMÈS / MACHANN NAN LARI ....5 BÒN /TRAVAY KAY MOUN....6 OUVRIYE.....7 LÒT _____ 8 (PRESIZE)	→**11**

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
10	Ki lès ki okipe (non ti moun nan) lè w pa la ?	Manman (ANKETE)..... A MARI/PATNÈ ..... B TIMOUN KI PI GRAN .....C VWAZEN /ZANMI …….E BÒN /SÈVANT ..... F LÒT _____ x (PRESIZE)	
11	Ki kote w fè manje?	Anndan kay la.... …… 1 Nan yon pyès ki nan lakou a (kizin). 2 Nan pa pòt kay la ..... 3 Nan lakou a lwen pòt kay la .....4 Lòt kote _____ .....8 (PRESIZE)	
12	Ak ki sa ou kwit manje pi souvan ?	Ak Bwa.....1 Ak Chabon.....2 Ak Alkòl……..3 Ak Kewozèn.....4 Ak Elektrisite .....5 Ak gaz pwopàn .....6 Ak Lòt _____ .8 (Presize)	
13	Eske konn gen lafimen andan kay la lè y ap fè manje?	NON……1 WI……2 PA KONNEN……...9	
14	Koulye a, m vle poze w kesyon sou manje, ou menm oswa lòt fanmi k nan kay la te manje yè. LI TOUT BAGAY SA YO : a. Diri, pen, espageti, labouyi, mayi moulen, konflèks, biskwit, ble, pitimi ? b. Patat, ponmdetè, manyòk? c. Legim ? d. Fwi ?	**NON** **WI** 0 1 0 1 0 1 0 1	

No	KESYON YO AK ENDIKASYON YO	KÒD YO		ALE NAN
	e. Vyann bèf, chochon, oubyen lòt kalite vyann?	0	1	
	f. Ze ?	0	1	
	g. Pwason,krab,lanbi,krevet etc..)	0	1	
	h. Pwa, nwa , pistach?	0	1	
	i. Fwomaj, lèt oubyen lòt bagay ki fèt ak lèt ?	0	1	
	j. Manje ak lwil, bè, oubyen la kochon ?	0	1	
	k. Sik oswa siwo myèl ?	0	1	
	l. Lòt bagay tankou kafe, te oubyen ji ?	0	1	

SWEN PRENATAL YO

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
15	Eske w te al konsilte/we yon moun lè w te ansent (non timoun nan) Si WI: Ki moun ou te wè ? ENSISTE POU KONNEN KI JAN DE PWOFESYONEL, MANDE LI SI PAGEN LOT, EPI EKRI TOUT MOUN MANMAN AN DI.	**PWOFESYONÈL LASANTE** DOKTÈ .....A ENFIMYÈ /SAJFAM…….B OKSILYÈ /SAJFAM .....C **LOT MOUN** MATWÒN.....D AJAN SANTE KOMINOTÈ.....E LÒT _____ x (PRESIZE) PÈSONN Z	→**24**
16	Konbyen fwa w t al pran swen lè w te ansent la ?	KANTITE FWA.....☐☐	
17	Eske w te genyen yon kat sante fanm lè w te ansent (non ti moun na) ? SI WI, kote kat la ?	Wi / verifye……1 KAT LA PA LA.....2 PA T JANM TE GEN KAT.. 3	→**20** →**20**
18.	GADE KAT LA EPI EKRI KANTITE VIZIT PRENATAL LI TE FÈ LÈ LI TE ANSENT (non ti moun nan)	KANTITE VISIT ☐☐	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
19.	GADE KAT LA EPI EKRI DAT YO POU CHAK PIKI TT KI MAKE SOU KAT LA	JOU MWA ANE 1è ☐☐ ☐☐ ☐☐☐☐ 2èm ☐☐ ☐☐ ☐☐☐☐ 3èm ☐☐ ☐☐ ☐☐☐☐ 4èm ☐☐ ☐☐ ☐☐☐☐	
20	Le w te ale nan klinik pou fanm ansent nan gwosès (non timoun nan), èske gen yon moun ki te pale w de : LI TOUT BAGAY SA YO: a) Kouman manman ka bay tibebe a jèm SIDA . b) Kouman pou fè pou pa pran jèm SIDA ? c) Fè tès SIDA ?	**Non WI PA KONNEN** a) ……: 1 2 9 b) …….. : 1 2 9 c) ……: 1 2 9	
21	M pa bezwen konnen rezilta tès la, men èske ou te fè tès SIDA le w te ale nan klinik pou fanm ansent	NON ……1 WI ……..……2	**→24**
22	Ki kote ou te fè tès la ?	**EKRI KOTE A LA** _____ (PRESIZE KOTE A)	
23	Sonje, m pa bezwen konnen rezilta tès la, men èske w konnen rezilta tès la ?	NON ……1 WI …….2	
24	Anvan ou te akouche (non timoun na), èske yo te ba w yon piki nan bra w pou anpeche ti bebe a pran tetanòs, sa vle di, fè kriz lè l fin fèt ?	NON.....1 WI.....2 PA KONNEN..... .9	
25	Lè w te ansent (non timoun nan), eske yo te ba w oswa ou te achte kèk grenn oswa siwo ki te gen fè ak asid folik ladan l ? GRENN OSWA POU SAN	NON.....1 WI.....2 PA KONNEN 9	**→27** **→27**
26	Pandan konbyen jou w te pran grenn nan oswa siwo a ?	KANTITE JOU ☐☐☐	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	SI LI PA KONEN MANDE L APEPRÈ KANTITE SEMEN OU MWA EPI KALKILE KANTITE JOU A	PA KONNEN 999	
27	Le yon moun ansent, ki sentòm ou panse ki dwe fe w al chèche swen touswit EKRI TOUT SA LI DI	LAFYÈV.....…….A ESOUFLEMAN..... …. B BAY SAN PA BA (EMORAJI)….. C MAL TÈT……. D ANFLAMASYON KÒ/ MEN/FIGI….E LÒT_____ x (PRESIZE) PA KONNEN ..... …Z	→**29**
28	Si w ta gen youn nan sentòm sa yo ki kote w ta kouri ale an premye pou kapab pran swen ?	Lopital …….. ……..1 Sant sante…… ……..2 Dokte Prive…… 3 Enfimye…….. 4 Oksilye…….. 5 Matwòn fòme(ak bwat)…… .. 6 Matwòn ki pa fòme/fanmi (san bwat) …7 LÒT _____... ….....8 (PRESIZE) PA KONNEN……..9	

1.8

PTME

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
29.	Eske yon manman ka bay pitit li jèm SIDA ? LI TOUT KATEGORI SA YO: a) pandan gwosès la? b) pandan akouchman ? c) pandan lap bay tete ?	**Non Wi Li pa konnen** a) Pandan gwosès la. … . 1 2 9 b) Nan akouchman an……. .1 2 9 c) Nan bay tete a …… 1 2 9	
30	Si yon manman konnen li gen jèm SIDA, èske l ta dwe bay ti bebe a tete ?	NON ……1 WI ……..2 PA KONNEN ……9	

31	Si yon manman pa konnen si li gen jèm SIDA ak si li pa genyen l, èske l ta dwe bay ti bebe a tete ?	NON ……1 WI ……..……..……..2 PA KONNEN ……..……9	

1.9

AKOUCHMAN AK SWEN RAPID POU TI BEBE KI FENK FÈT
KOTE A AK ASISTANS AKOUCHMAN AN

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
32	Ki kote w te akouche (non timoun nan) ?	**NAN KAY** KAY PA W……..……..1 LÒT KAY……...……..2 **ETABLISMAN SANITÈ** Lopital …….. ……3 Sant sante…… ……..4 LÒT_____.....8 (PRESIZE)	**→34** Si li te akouche nan yon etablisman Sanitè, ale nan kesyon 34
33	Pou ki sa fanm yo akouche nan kay ? **EKRI TOUT SA LI DI**	Lopital twò chè…….....A Eksperyans pase a/ pa gen pwoblèm avèk akouche kay…B BLopital pa akeyi moun byen ..... …. D Distans la twò lwen.....…E Dwe okipe lòt timoun yo nan kay la ….F Pa gen transpò..... G Lopital vle di sezaryèn .....H Pa gen doktè/ Pa gen fanmsaj nan lopital la..... I Kalite swen yo pa bon nan lopital la .....J LÒT..... x (PRESIZE)	
34	Ki moun ki te akouche-w lè w tap fè (non timoun nan) ? EKRI TOUT SA LI DI	**PWOFESYONÈL LASANTE** DOKTÈ .....A ENFIMYÈ / SAJFAM.....B OKSILYÈ .....C **LÒT MOUN** MATWÒN FÒME……D MATWÒN KI PA FÒME…… .. ...E (Bay non matwòn nan_____) AJAN SANTE KOMINOTÈ…… …F MANM FANMI _____.... ...G	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		(PRESIZE) 1.9.a.i.1.1 LÒT_____..... .....x (PRESIZE) PÈSONN……..Z	
35.	Eske yo te itilize mareyeèl pwòp ?	NON..... ….....1 WI.....2 PA KONNEN 9	
36.	Ki sa yo te itilize pou koupe kòd lonbrit la ?	JILÈT NÈF.....1 LÒT BAGAY.....2	
37	Ki moun ki te koupe kòd lonbrit la?	**PWOFESYONÈL LASANTE** DOKTÈ .....1 ENFIMYÈ / SAJFAM.....2 OKSILYÈ .....3 **LÒT MOUN** MATWÒN FÒME……..4 MATWÒN KI PA FÒME…….. ……. 5 (Bay non matwòn nan _____) AJAN SANTE KOMINOTÈ…… …6 MANM FANMI _____..... 7 (PRESIZE) LÒT_____.....8 (PRESIZE) PÈSONN……9	
38.	Ki sa yo mete sou lonbrit la lè yo fin koupe l ?	LWIL .....1 MOSO TWAL .....2 FAB/SAVON.....3 POUD DETAC .....4 ANTIBIOTIK/ANTISEPTIK .....5 ALKÒL .....6 ANYEN .....7 LÒT _____ .....8 (PRESIZE) PA KONNEN …… …… 9	
39.	Eske yo te peze (non ti moun nan) lè l te fenk fèt la?	WI……..……1 NON…… 2 PA KONNEN……..9	
40.	Lè (non timoun nan) te fin fèt , è eske yo te konsilte w	NON..... 1 WI..... 2	→**46**
41	Konbyen jou, aprè akoucheman an ou te al konsilte pou premye fwa ? EKRI <<00>> JOU, SI SE TE MENM JOU A.	JOU APRÈ AKOUCHMAN SEMÈN APRÈ AKOUCHMAN	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	JOU A.	PA KONNEN.....99	
42	Ki lès ki te konsilte w lè sa a ? ENSISTE POU L BA W MOUN KI PI FÒME A .	**PWOFESYONÈL LASANTE** DOKTÈ .....1 ENFIMYÈ / SAJFAM.....2 OKSILYÈ .....3 **LÒT MOUN** MATWÒN FÒME……4 MATWÒN KI PA FÒME……..... 5 (Bay non matwòn nan _____) AJAN SANTE KOMINOTÈ…….... 6 MANM FANMI _____..... ….7 (PRESIZE) LÒT_____.....8 (PRESIZE) PÈSONN……..9	
43	Ki sa yo te kontwole lè yo te konsilte-w la)	Anyen……..……...A Emoraji (pase san pa ba)……B Si gen lafyèv …… C Enfeksyon nan chouchoun ki santi .move...D Kontwole tansyon.....E LÒT_____.....x (PRESIZE)	
44	Ki sa yo te fè pou (non timoun nan)?	Anyen……A Poze kèk kesyon sou alètman matènèl …B Kontwole kòd lonbrit la.……C Ba l kèk vaksen……E Kontwole souf li……F LÒT_____.....x (PRESIZE)	
45	Aprè akouchman w, èske yo te konseye w sou bagay sa yo: KELKE SWA MOUN LI TE WÈ A **LI TOUT BAGAY SA YO** Kantite tan ki separe timoun yo Manje timoun Vaksen timoun nan Dyare timoun Siy danje maladi timoun	**Non Wi** Kantite tan ki separe timoun yo 1 2 Manje timoun 1 2 Vaksen timoun nan 1 2 Dyare timoun 1 2 Siy danje maladi timoun 1 2	
46	Pandan de premye mwa aprè akoucheman an, èske w te jwenn yon dòz vitamin A, tankou sa a ?[1] MONTRE L VITAMIN A.	NON.....……1 WI.....2 PA KONNEN ……9	
47	Ki siy danje ou wè aprè akouchman	FYÈV .....A	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	an ki ka fe w kouri al chèche swen byen vit ? EKRI TOUT SA LI DI	BAY SAB PA BA .....B EKOULMAN CHOUCHOUN KI SANTI MOVE...C LÒT_____..... x (PRESIZE) PA KONNEN .....Z	
48	Aprè akouchman ki a saw panse yon ti bebe ka genyen pou-w ta oblije kouri menen l lopital san pedi tan) EKRI TOUT SA LI DI	Pa gen apeti……A Pa tete byen……B Lafyèv……C Vomisman……D Kriz……E Resoufle .....F Pa bouje .....G Lonbrit la tou wouj ..... H Je wouj / malozyè .....I Jonis / Pò blanch ……..J Dezidratasyon……K LÒT_____ x (PRESIZE) PA KONNEN .....Z	

1.10

ALETMAN AK MANJE TIMOUN NAN

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
49	Eske w te bay (non timoun nan) tete?	JAMÈ .....1 WI 2	→55
50	kilè ou te komanse bay (non timoun nan) tete apre li te fin fèt?	TOUTSWIT APRE AKOUCHMAN/OSINON APRÈ ……..…1 APRÈ KÈK TAN NAN PREMYE JOU-A……2 Dezyèm jou a ou pita……3 Pa sonje.....9	
51	Eske w te bay (non timoun nan) premye lèt jòn nan lè li te fin fèt? SE PREMYE LÈT KI SOTI NAN TETEW LÈ TI MOUN NAN FENK FÈT	WI ..... 1 NON..... 2 PA KONNEN 9	
52	Eske w te bay (non timoun nan) dlo sikre oubyen nenpot ki bagay tankou LÒK?	WI ..... 1 NON..... 2 PA KONNEN 9	
53	Eske wap bay (non timoun nan) tete kounyè-a?	WI ..... 1 NON..... 2	→55

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		PA KONNEN 9	
54	Pandan Konbyen mwa ou te bay (non timoun nan) tete? SI SE MWENS KE YON MWA, EKRI « 00 »	☐☐ MWA	
55	Eske ayè, ou te bay (non timoun nan) bwè bagay nan bibwon oubyen nenpot veso ki gen tetin?	NON..... 1 WI……..……2	
56	Kounye-a , mwen ta renmen mandew enfomasyon sou kalite likid (non ti moun nan) te bwè ayè, nan nwuit oswa lajounen. Eske (non ti moun nan) te bwè kèk nan bagay sayo ayè, nan nwuit oswa lajounen? LI TOU LIKID KI LAYO DE SOTI NAN a POU RIVE NAN B LÈT maman ak Dlo DLO SIKRE JI FWI LÈT AN POUD TE/TIZAN SIWO MYÈL TETE	LÈT maman ak Dlo…….A DLO……B DLO SIKRE .....C JI FWI ..... …D LÈT AN POUD ..... E TE/TIZAN.....F SIWO MYÈL .....G TETE……..……..H LÒT_____x (PRESIZE)	
56a	Eske w te bay (non timoun nan) manje labouyi oubyen ti pire, ki ba bagay dlo sèlman ?	NON..... 1 →57 WI……..……2	
56b	Yè pandan jounen an, konbyen fwa (non timoun nan) te manje labouyi oubyen ti pire, ki ba bagay dlo sèlman ?	KANTITE Fwa .....☐☐ PA KONNEN 9	
57	Nan sis denye mwa ki sot pase yo, eske (non timoun nan) te pran yon doz Vitamin A, tankou sa a, ? **MONTRE MANMAN-AN KAPSIL LA**	NON..... 1 WI..... 2 PA KONNEN……..9	

1.11

TIMOUN MALAD

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
58	Eske pandan de dènye semenn ki sot pase yo, (non ti moun nan) te gen youn nan pwoblèm sa yo ? **LI TOUT BAGAY SA YO :** Dyare ? San nan tata ? Tous ? Soufle anlè ? Souf kout ? Fyèv? Malarya? Kriz?	DYARE .....A SAN NAN TATA ..... B TOUS.....C SOUFLE anlè ……...D RESPIRASYON RAPID /SOUF KOUT……E FYÈV .....F MALARYA .....G KRIZ..... H LÒT _____.....x ANYEN……Z	→ FIN
59	Eske w te jwenn konsey osinon remèd pou (non ti moun nan) ?	NON ……..1 WI…… ……2	→ 65
60	Lè w te remake sentòm sa yo sou (non ti moun nan) aprè konbyen tan w t al chache yon tretman ?	MENM JOU A.....0 NAN DEMEN.....1 DE (2) JOU.....2 TWA JOU OU PLIS…. 3	
61	Ki kote w te ale an premye pou kapab jwenn yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
62	Ki moun ki te deside ou ankouraje w, ale kote sa a pou maladi (non ti moun nana) ?	ANKETÈ ..... A MARI/PATNÈ ..... B GRANN LI C	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	EKRI TOUT SA LI DI.	BÈLMÈ .....D ZANMI / VWAZEN.....E LÒT _____ ..... x (PRESIZE)	
63	Eske ou te ale yon lòt kote pou pran konsèy osinon pou tretman pou maladi (non timoun nan) ?	NON.....1 WI 2	→ 65
64	Ki kote w t ale pou chache yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……..11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
65	Lè (non ti moun nan) te malad la, eskew te ba l mwens tete pase sa w te konn ba li anvan an, oubyen prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 TIMOUN PA T TETE……4 PA KONNEN 9	
66	Lè (non ti moun nan) te malad la, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 PA BWÈ ANYEN.....4 PA KONNEN 9	
67	Lè (non ti moun nan) te malad la, eskew te ba l mwens manje pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 PA MANJE ANYEN.....4 PA KONNEN 9	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
68	Pandan (non ti moun nan) t ap refè pou l sot nan maladi a, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS.....3 PA BWÈ ANYEN .....4 PA KONNEN 9	
69	**ALE NAN KESYON 58 E KONTWOLE REPONS MANMAN AN.** SI **A OU B:** APLIKE MODIL . **DYARE** SI **C, D, OU E:** APLIKE MODIL **Pwoblèm respitatwa** SI **F, G, H:** APLIKE MODIL **MALARYA**	**KONTWOLE KI MODIL POU APLIKE** **MODIL C** (**DYARE**) **MODIL A** (**Pwoblèm respiratwa**) **MODIL B** (MALARYA)	 → **72** → **70** → **71**
MODIL A : TRETMANT TIMOUN AK PWOBLÈM RESPIRATWA			
70	Ki medikaman (non ti moun nan) te bwè? **Pwoblèm respitatwa**? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN.....A ASPIRIN.....B ASETAMINOFÈN..... C AMOKSISIILIN ..... D ERITWOMISIN .....E ANPISILIN.....F KOTRIMOKSAZÒL……..…G PA KONNEN……..z LÒT_____ x (PRESIZE)	
MODIL B : TRETMAN TIMOUN KI GEN FYÈV			
71	Ki medikaman (non ti moun nan) te bwè pou lafyèv li a? EKRI TOUT SA LI DI. MANDE LI POU L MONTRE W YO.	ANYEN……A ASPIRIN……...B ASETAMINOFÈN ……..…..C KOTRIMOKSAZÒL……D KLOWOKIN ..…… E KININ ..... F PA KONNEN……..Z LÒT_____ x (PRESIZE)	
MODIL C : SWEN TIMOUN AVÈK DYARE			
72	Ki sa (non ti moun nan) te bwè pou trete dyare a ? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN..... A SEWÒM ORAL ..... B PREPARASYON NAN KAY...C GRENN OUBYEN SIWO.....D PIKI..... E PIKI NAN VENN (IV) ..... F REMÈD NAN KAY/	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		REMÈD TRADISYONÈL…….G PA KONNEN…… Z LÒT_____ x (PRESIZE)	
73	Eske (non ti moun nan) te pran zen pou dyare a ?	NON……1 WI……..……2 Si WI, pou konbyen jou : __ __	

FINI

==========

TIMOUN 12 - 23 MWA

==========

CONCERN, FOCAS, AK GRET ANSANM AVEK MINISTE SANTE PIBLIK REPIBLIK DAYITI
SANTE IBEN NAN POTOPRENS
Ankèt Rapid sou Konesans, Pratik e Kouveti (KPK)

VÈSYON 04 MAS 2006

Zon pwoje a ☐ Senmaten - 1, Site Okay - 2,
Dekayet-3, Jalouzi/Bwa Mokèt-4

Zòn sipèvisyon-an ☐

Nimewo echantiyon nan blok la ☐☐☐

Nimewo kay nan echantiyon an ☐☐☐ (pami kantite kay ki nan bok la)

Deskripsyon kay la _____

Nimewo rejis ☐☐

Non enketè a _____

Non sipèvizè a _____ _____

Verifye pa _____.
Sipevizè a

Dat entèvyou a ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Ranvoye pou ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Non manman-an _____ _____
Non Siyati

Laj Manman -an ☐☐ an

Kouman w rele pitit ki pi piti a _____ _____
Non Siyati

Se yon Tifi ☐ Tigason ☐

Dat li te fèt ☐☐ ☐☐ ☐☐☐☐ MANDE KAT Vaksen ou lot kat.
Jou mwa ane

Laj timoun nan ☐☐ mwa

OTORIZASYON MOUN KI REPONN

Bonjou/Bonswa. M rele _____, e m ap travay pou _____). N ap fè yon enkèt, nou ta swete w patisipe ladan. M ta renmen poze w kèk kesyon sou sante w, epi tou sou sante pitit ou ki pi piti a, sa ki gen mwens pase dezan. Enfòmasyon sa yo pral sèvi _____ak Ministe sante piblik pou planifye sèvis sante l yo e pou l evalye si yo koresponn ak objektif li yo pou amelyore sante timoun nan. Ankèt la pran nòmalman **30** minit. Nenpòt enfòmasyon ou bay la, l ap rete sekrè, e pèsonn p ap konnen l.

Patisipasyon nan ankèt sa a li volontè, e ou ka deside pa reponn ak kèk kesyon pèsonèl oubyen nenpòt ki lòt kesyon. Men, nou swete ou patisipe nan ankèt sa a, piske sa ou panse a trè enpòtan.

Koulye a, èske ou gen kesyon pou poze m sou ankèt la ?

Siyati anketè a: _____

Dat: _____

ANKETE A AKSEPTE POU L ANKETE ANKETE A PA AKSEPTE POU L ANKÈTE

PATI I: ENFOMASYON SOU MANMAN PITIT LA AK SITYASYON FANMI LI

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
1.	Depi konbyen tan ou rete nan katye sa a?	Ane ☐☐ Mwa ☐☐	
2.	Ki lès ki chèf kay la?	MANMAN (ANKETE)).....1 MARI / PATNÈ .....2 LÒT _____8 (PRESIZE)	
3	Konbyen timoun ki gen pi piti pase senk an kav viv nan kay la?	☐ Timoun	Si se yon sèl timoun, ale nan kesyon →**7**
4.	Ti moun ki vin avan-an. (non ti moun nan) la ki dat li fèt	☐☐ jou ☐☐ mwa ☐☐☐☐ ane	
5.	Kijan li rele	non_____ siyati _____	
6	Se yon	Tifi ☐ Ti gason ☐	
7	Eske 'w te ale lekol.	Non……1 Wi……..2	→**9**
8.	Nan ki klas ou te rive ? KALKILE KONYEN ANE KLAS LI FÈ-A VO	☐☐ ane	
9	Eske w ap travay ? SI WI, Ki kalite travay w ap fè ? SI NON, ANSÈKLE « PA P TRAVAY »	PA P TRAVAY .....1 ATIZANA.....2 FÈ JADEN .....3 VANN MANJE .....4 KOMÈS / MACHANN NAN LARI ...5 BÒN /TRAVAY KAY MOUN....6 OUVRIYE.....7 LÒT _____..... 8 (PRESIZE)	→**11**
10	Ki lès ki okipe (non ti moun nan) lè w pa la ?	Manman (ANKETE)..... A MARI/PATNÈ ..... B TIMOUN KI PI GRAN C	

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		VWAZEN /ZANMI ……E BÒN /SÈVANT ..... F LÒT _____..... x (PRESIZE)	
11	Ki kote w fè manje?	Anndan kay la.... …… 1 Nan yon pyès ki nan lakou a (kizin)....2 Nan pa pòt kay la ..... 3 Nan lakou a lwen pòt kay la .....4 Lòt kote _____ .....8 (PRESIZE)	
12	Ak ki sa ou kwit manje pi souvan ?	Ak Bwa.....1 Ak Chabon.....2 Ak Alkòl……..3 Ak Kewozèn.....4 Ak Elektrisite.....5 Ak gaz pwopàn .....6 Ak Lòt _____ .8 (Presize)	
13	Eske konn gen lafimen andan kay la lè y ap fè manje?	NON……1 WI……2 PA KONNEN……...9	
14	Koulye a, m vle poze w kesyon sou manje, ou menm oswa lòt fanmi k nan kay la te manje yè. LI TOUT BAGAY SA YO :	**NON** **WI**	
	a. Diri, pen, espageti, labouyi, mayi moulen, konflèks, biskwit, ble, pitimi ?	0 1	
	b. Patat, ponmdetè, manyòk?	0 1	
	c. Legim ?	0 1	
	d. Fwi ?	0 1	
	e. Vyann bèf, chochon, oubyen lòt kalite vyann?	0 1	
	f. Ze ?	0 1	
	g. Pwason,krab,lanbi,krevet etc..)	0 1	
	h. Pwa, nwa , pistach?	0 1	
	i. Fwomaj, lèt oubyen lòt bagay ki fèt ak lèt ?	0 1	
	j. Manje ak lwil, bè, oubyen la kochon ?	0 1	
	k. Sik oswa siwo myèl ?	0 1	
	l. Lòt bagay tankou kafe, te oubyen ji ?	0 1	

DLO AK SANITASYON

No.	KESYON AK ENDIKASYON YO	KÒD YO	ALE NAN

No.	KESYON AK ENDIKASYON YO	KÒD YO	ALE NAN
74	M ta renmen poze w kèk kesyon sou Dlo nou bwè lakay nou yo ak twalèt nou itilize Ki kote nou pi souvan pran dlo pou nou bwè nan fanmi-an?	TIYO PIBLIK GRATIS.....1 TIYO PEYE.....2 TIYO NAN KAY LA /PRIVE.....3 SITÈN.....4 RIVYÈ.....5 SOUS.....6 PI.....7 DLO LAPLI.....8 LÒT_____x (PRESIZE)	
75	Eske ou trete dlo nou itilize pou nou bwè nan kay la ?	NON.....1 WI.....2	→**78**
76	Ki sa ou itilize pi souvan pouw trete dlo nou bwè nan kay la ? ANTOURE PLIS PASE YON REPONS SELMAM SI MOUN NAN ABITYE ITILIZE PLISYÈ POUL TRETE DLO	SEDIMANTASYON.....A KOULE DLO-A NAN MOSO TWAL.....B BOUYI DLO-A.....C METE KLORÒS OSINON JIF NAN DLO-A..D FILTÈ.....E TRÈTMAN AVÈK SOLÈY.....F LÒT_____x (PRESIZE) PA KONNEN.....Z	→**78**
77	Ki dènye fwa ou te itilize metòd sa-a pouw te trete dlo nan kay la?	JODI-A .....1 AYÈ... ....2 DEPI PLIS PASE YON JOU.....3 PLIS PASE YON SEMÈN.....4 YON MWA E MENM L PLIS..... 5 PA SONJE.....9	
78	Ki kalite twalèt moun lakay ou sèvi? SI SE LATRIN PIBLIK, MANDE KI KALITE, ANTOURE NIMEWO 2 NAN KESYON 79 EPI ALE NAN KESYON 80	PA GEN TWALÈT/NAN RAJE.....1 TWALÈT KONFÒMODÈN..... .....2 LATRIN,.....3 TWOU.....4 FÒS VANTILE..... 5 LÒT _____ ..... 8 (PRESIZE)	→**80**
79	Eske twalèt w ap sèvi a gen lòt moun ki sèvi ladann ?	NON.....1 WI.....2	
80	Ki sa w fè ak tata ti bebe yo, e ak tata timoun ki pa ka ale nan twalèt pou kont yo?	JETE L NAN LATRIN..... .....1 ANTERE L NAN LAKOU.....2 LI PA JETE L/LI KITE L ATÈ A ....3 LÒT_____.....8 (PRESIZE)	
81	Ki sa w fè ak fatra yo?	JETE L NAN TWOU SAN KOUVÈTI.... 1	

No.	KESYON AK ENDIKASYON YO	KÒD YO	ALE NAN
		JETE L NAN TWOU AK KOUVÈTI.....2 JETE L NENPÒT KOTE .....3 BOULE L.....4 KAMYON FATRA .....5 LÒT _____ 8 (PRESIZE)	

VAKSINASYON TIMOUN YO

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NA
82	Eske (non ti moun nan) gen yon kat vaksen osinon lòt kat kote yo ekri tout sa ki fèt pou li? SI WI : M KA WÈ L SIL VOU PLÈ?	WI, ANKETÈ A GADE L …… 1 PA LA / PÈDI/ ANFOURAYE… 2 PA T JANM TE GEN KAT 3 LI PA JANM PRAN VAKSEN 4 PA KONNEN.....9	 →**86** →**86** →**88** →**86**
83	MAKE DAT VAKSEN YO KI SOU KAT LA POU CHAK VAKSEN KI EKRI.	EKRI «11/11/1111» NAN KOLONN SI KAT LA ENDIKE YO TE BAY YON VAKSEN, MEN DAT LA PA ANREJISTRE **JOU MWA ANE**	
	a. BCG	BCG...	
	b. POLIO 0 (POLIO DEPI LI FÈK FÈT)	P0	
	c. POLIO 1	P1	
	d. POLIO 2	P2	
	e. POLIO 3	P3	
	f. DTPER 1	DTPER 1.....	
	g. DTPER 2	DTPER 2.....	
	h. DTPER 3	DTPER 3.....	
	i. ROUGEOLE	ROUG	
	j. VITAMIN A (DÒZ PI RESAN)	VIT. A	
84	KONTWOLE KAT (non ti moun nan) POU WÈ SI YO TE PRAN PWA L PANDAN KAT DÈNYE MWA YO	NON..... 1 WI..... 2 PAGEN PLAS NAN KAT LA POU EKRI PWA……9	
85	Eske gen kèk vaksen (non timoun nan) te pran ki pa enskri nan kat sa a, tankou vaksen yo te bay nan jounen kanpay vaksinasyon nasyonal la ?	NON.....1 WI.....2 PA KONNEN……9	→**88** →**87** →**88**
86	Eske gen kèk vaksen (non timoun nan) te pran tankou vaksen yo te bay nan jounen kanpay	NON.....1 WI.....2	→**88** →**87**

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NA
	vaksinasyon nasyonal la ?	PA KONNEN……9	→**88**
87	Eskew ka dim si (non ti moun nan) te pran youn nan vaksen sa yo **:**		
87a	Vaksen BCG kont tibèkiloz, se yon piki yo bay nan bra oswa sou zepòl dwat, ki toujou kite yon mak ?	NON.....1 WI.....2 PA KONNEN 9	
87b	Vaksen polio a, se kèk gout yo lage nan bouch ?	NON.....1 WI.....2 PA KONNEN 9	→**87e** →**87e**
87c	Ki lè yo te ba l premye dòz vaksen kont polio a ?	KOU LI FENK FÈT ..... 1 APRÈ KÈK TAN 2	
87d	Konbyen fwa yo te ba li vaksen kont polio a ?	KANTITE FWA..... ☐☐	
87e	Vaksen DTPER a, se yon piki yo bay nan kwyis oubyen nan dèyè, pafwa yo konn bay li an menm tan ak gout kont polio yo ?	NON.....1 WI.....2 PA KONNEN 9	→**87g** →**87g**
87f	Konbyen fwa ?	KANTITE FWA..... ☐☐	
87g	Yon piki pou pwoteje l kont lawoujòl ?	NON.....1 WI.....2 PA KONNEN 9	
88	Eske (non ti moun nan) te pran deja yon dòz Vitamin A, tankou sa pandan **4** dènye mwa ki sot pase yo ? MONTRE L AMPOUL LA	NON.....1 WI.....2 PA KONNEN ……..9	

MOUSTIKÈ

No	KESYON AK ENDIKATE YO	KÒD YO	ALE NAN
89	Ou gen moustikè?	NON……1 WI……..2	→**92**
90	Eske moustikè-a tou vini ak ensektisid ladan?	NON……1 WI …… ……..2 PA KONNEN ……..9	
91	Eske (Non timoun nan) te dòmi yè swa anba	NON……1	

No	KESYON AK ENDIKATE YO	KÒD YO	ALE NAN
	yon moustikè ?	WI……..2	

SENTÒM YON TIMOUN MALAD

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
92	Ki siy ak sentòm yon timoun trè malad ka genyen ki fè w oblije kouri al chèche swen avèl ? EKRI TOUT SA LI DI.	Li pa ka manje / bwè /tete.....A Sanble l pa pote l byen/ li pa jwe nòmalman .....B Souf kout.....C Gwo lafyèv.....D Li pa ka chita pou kont li .....E Vomisman .....F Li kagou / dekonpoze .....G Kriz.....H LÒT _____ .....x (PRESIZE) PA KONNEN …….....Z	
93	Ki sentòm yon timoun genyen lè li fè nemoni ? EKRI TOUT SA LI DI.	Kriz.....A Soufle an lè.....B Mal pou respire .....C Kòt li ap rantre,venn koul detire....D Lafyèv……..E LOT _____ .....x (PRESIZE) PA KONNEN …….....Z	
94	Ki siy ak sentòm ki ka fè w al chache konsèy oswa tretman pou lè pitit ou gen dyare? EKRI TOUT SA LI DI.	Dyare pandan 3 jou osinon plis.....A San nan tata .....B Dezidrate /bouch li sèch .....C Mitan tèt la rantre li fon .....D Pipi a tou piti .....E Lafyèv .....F Li pa vle manje .....G Trou je l fon .....H Eksite /Rechinya.....I Kò lage……J LÒT _____.....x (PRESIZE) PA KONNEN …….....Z	
95	Ki sa ki ka bay lafyèv malarya? EKRI TOUT SA LI DI.	MARENGWEN .....A LOUGAWOU.....B DRÒG NAN PIKI .....C TRANSFISYON SAN.....D PIKI .....E PATAJ JILÈT .....F LÒT _____ x (PRESIZE) PA KONNEN..... Z	
96	Eske ou konn tande pale de SEWÒM ORAL ? SI WI, MANDE MANMAN AN P OU L EKSPLIKE W KOUMAN YO PREPARE YON	WI ( ) NON ( ) EKSPLIKE KÒRÈKTEMAN……1	

	SEWÒM ORAL SI NON, ANSÈKLE 3 (LI PA JANM TANDE PALE DE SA). APRÈ MANMAN AN FIN EKSPLIKE PREPARASYON SEWÒM ORAL LA, EKRI SI LI TE BAY EKSLIKASYON AN KÒRÈKTEMAN OU PA. ANSÈKLE 1 [KÒRÈKTEMAN] SI MANMAN AN TE PALE SOU BAGAY SA YO: • SÈVI AK 1 LIT DLO PWÒP (1 LIT= 3 BOUTÈY KOLA) • VIDE TOUT SACHE POUD LA NAN DLO A • BWASE L JISKASKE POUD LA FÒN	PA EKSPLIKE KÒRÈKTEMAN….. 2 PA T JANM TANDE PALE DE SEWÒM ORAL ……..3	→98
97	Kote w konn jwenn SEWÒM ORAL la? EKRI TOUT SA LI DI	Machann nan lari……A Boutik……B Famasi ……C Distribitè Kominotè ……D Zanmi /Fanmi ……E Nan sant sante-a……F LÒT _____ x (PRESIZE) PA KONNEN…… Z	

DISTANS ANT TIMOUN YO

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
98	Eske w ansent ?	NON ..... 1 WI..... 2 PA SI..... 8	→**101**
99	Eske w ta renmen fè yon lòt timoun nan 2 lane k ap vini yo ?	NON ..... 1 WI..... 2 PA SI..... 8	→**100** →**101** →**100**
100	Eske w ap fè yon bagay oswa w ap swiv yon metòd pou pa tonbe ansènt kounye a? SI NON, ANSÈKLE «01» OKENN METÒD SI WI, MANDE : « Ki prensipal metòd ou menm oswa mari w/patnè w ap itilize pou pa	OKENN METÒD ..... 01 NÒPLAN (piki 5 an) ..... 02 PIKI (3 mwa) ..... 03 GRENN ..... 04 ESTERILÈ ..... 05 METÒD BARYÈ/DYAFRAG. 06	

	tonbe ansent ? » ANTOURE RESPONS KI KOREK LA	KAPÒT ..... 07 MOUS/JÈL ..... 08 LIGATIDÈTWOMP..... 09 VAZEKTOMI..... 10 ALÈTMAN MATÈNÈL. PA GEN RÈG (TETE SÈLMAN ..... 11 ALMANAK ..... 12 PA FÈ BAGAY ..... 13 VOYE DEYÒ..... 14 LÒT_____ 88 (PRESIZE)	

VIH/SIDA

No.	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
101	Koulye a m ta renmen pale sou yon lòt bagay. Eske ou konn tande pale sou yon maladi ki rele SIDA?	NON..... 1 WI..... 2	→**111**
102	Eske moun ka pran jèm SIDA si li fè bagay ak yon sèl patnè ki pa enfekte e ke patnè sa a pa fè bagay ak ankenn lòt moun ?	NON..... 1 WI..... 2 PA KONNEN ……9	
103	Eske moun ka pran jèm SIDA si li sèvi ak kapòt chak fwa l ap fè bagay?	NON..... 1 WI..... 2 PA KONNEN ……9	
104	Eske moun ka pran jèm SIDA si li manje nan menm asyèt ak yon moun ki gen SIDA a?	NON..... 1 WI..... 2 PA KONNEN ……9	
105	Eske moun ka pran jèm SIDA si li pa fè bagay ditou?	NON..... 1 WI..... 2 PA KONNEN ……9	
106	Eske w t ap achte manje nan men yon machan manje si w ta konnen moun sa a gen jèm SIDA a?	NON..... 1 WI..... 2 PA KONNEN ……9	
107	Si w gen yon moun nan fanmi w ki gen jèm SIDA, èske w ta renmen sa rete sekre ou non ?	WI, RETE AN SEKRE ……..1. NON……..……2 PA KONNEN/PA SI/SADEPAN…3.	
108	Si yon moun nan fanmi w ta tonbe malad ak SIDA, ou t ap dakò pou okipe l lakay ou ?	NON..... 1 WI..... 2 PA KONNEN ……9	
109	Nan dènye douz mwa k sot pase yo, èske w te konnen dirèkteman yon moun ke yo te refize ba l sèvis medikal swen paske yo te sispèk li gen jèm SIDA oubyen paske li gen jèm SIDA ?	WI ……..……1 1 NON ……..…… 2 2 PA KONNEN MOUN AK VIH/SIDA. 3 3 8 PA KONNEN/PA SI ……9	

No.	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
110	Eske w dakò oswa ou pa dakò ak pawòl ki di : Moun ki gen jèm SIDA yo ta dwe kondane yo paske y ap pote maladi sa a nan kominote a.	NON..... 1 WI..... 2 PA KONNEN …….9	
111	GADE KESYON 101: ❑ [SI LI KONN TANDE PALE DE SIDA, MANDE L:] Apa SIDA, Eske w konn tande pale de lòt enfeksyon moun ka pran nan fè bagay ? ❑ [SI LI PA KONN TANDE PALE DE SIDA, MANDE L:] Eske w konn tande pale de enfeksyon moun ka pran nan fè bagay ?	NON..... 1 WI..... 2	→113
112	Eksplike sentòm fanm yo konn genyen lè yo pran yon enfeksyon nan fè bagay. **[PA LI REPONS YO FÒ.** **POU CHAK SENTOM, ANSÈKLE '1' SI LI PA DI L. E ANSÈKLE '2' SI LI DI L.]** a) DOULÈ ANBA TIVANT 1 2 b) PÈT VAJINAL 1 2 c) PÈT KI GEN MOVÈZ ODÈ d) KANAL BOULE e) TI BLESE NAN BOUBOUN f) GLANN NAN KWEN LÈN N g) GRATE 1 2 h)LÒT _____ i) PA GEN REPONS ……..99	**NON WI** Y N a.) DOULÈ ANBA TIVANT 1 2 1 2 b) PÈT VAJINAL 1 2 1 2 c) PÈT KI GEN MOVÈZ ODÈ 1 2 1 2 d) KANAL BOULE 1 2 e) TI BLESE NAN BOUBOUN 1 2 f) GLANN NAN KWEN LÈN N 1 2 g) GRATE 1 2 1 2 h)LÒT _____ 1 2 i) PA GEN REPONS ……..9 1 2	

1.12

1.13

1.14

KONTAK AK SOUS ENFÒMASYON SOU LASANTE

N°	KESYON YO AK ENDIKASYON YO	KÒD YO			ALE NAN
113	Mwa pase a, konbyen fwa w t al kote youn nan moun sa yo : LI CHAK MO YO EPI MANDE MANMAN-AN SI LI KON AL KONTAKTE MOUN SA-A SOUVAN, PAFWA OUBYEN JAMÈ	SOUVAN (4 fwa ou plis)	PAFWA (1-3 fwa)	JAMÈ (0 fwa)	
	DOKTÈ ?	1	2	3	
	ENFIMYÈ/FANMSAJ ?	1	2	3	
	AJAN SANTE ?	1	2	3	
	MANM ÒGANIZASYON DE BAZ ?	1	2	3	
	MOUN RESKONSAB NITRISYON ?	1	2	3	
	MATWÒN FÒME ?	1	2	3	
	MEDSEN FÈY ?	1	2	3	
114	Pandan dènye mwa, eske-w konn tande mesaj sou lasante Pa ki mwayen LI CHAK MWAYEN YO, EPI ANTOURE YOUN OUBYEN 2. OU DWE ANTOURE YOUN (1) OUBYEN 2 POU CHAK MWAYEN		NON	WI	
	RADYO ? (estasyon _____)		1	2	
	JOUNAL ?		1	2	
	TELEVIZYON ?		1	2	
	MANM ÒGANIZASYON DE BAZ?		1	2	
	AJAN SANTE?		2	2	
	LÒT (PRESIZE)_____)		2	2	

TIMOUN MALAD

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
115	Eske pandan de dènye semenn ki sot pase yo, (non ti moun nan) te gen youn nan	DYARE .....A SAN NAN TATA ..... B	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	pwoblèm sa yo ? **LI TOUT BAGAY SA YO :** Dyare ? San nan tata ? Tous ? Soufle anlè ? Souf kout ? Fyèv? Malarya? Kriz?	TOUS.....C SOUFLE anlè ……..D RESPIRASYON RAPID /SOUF KOUT……..E FYÈV .....F MALARYA .....G KRIZ..... H LÒT _____.....x ANYEN……Z	→131
116	Eske w te jwenn konsey osinon remèd pou (non ti moun nan) ?	NON ……..1 WI…… ……2	→ 122
117	Lè w te remake sentòm sa yo sou (non ti moun nan) aprè konbyen tan w t al chache yon tretman ?	MENM JOU A.....0 NAN DEMEN.....1 DE (2) JOU.....2 TWA JOU OU PLIS…. 3	
118	Ki kote w te ale an premye pou kapab jwenn yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……..03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……..11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
119	Ki moun ki te deside ou ankouraje w, ale kote sa a pou maladi (non ti moun nana) ? EKRI TOUT SA LI DI.	ANKETÈ..... A MARI/PATNÈ ..... B GRANN LI ..... C BÈLMÈ ..... D ZANMI / VWAZEN..... E LÒT _____..... x (PRESIZE)	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
120	Eske ou te ale yon lòt kote pou pran konsèy osinon pou tretman pou maladi (non timoun nan) ?	NON.....1 WI.....2	→ 122
121	Ki kote w t ale pou chache yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……..03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
122	Lè (non ti moun nan) te malad la, eskew te ba l mwens tete pase sa w te konn ba li anvan an, oubyen prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 TIMOUN PA T TETE……4 PA KONNEN 9	
123	Lè (non ti moun nan) te malad la, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 PA BWÈ ANYEN.....4 PA KONNEN 9	
124	Lè (non ti moun nan) te malad la, eskew te ba l mwens manje pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 PA MANJE ANYEN.....4 PA KONNEN 9	
125	Pandan (non ti moun nan) t ap refè pou l sot nan maladi a, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS.....1 MENM KANTITE .....2 PLIS .....3 PA BWÈ ANYEN .....4 PA KONNEN 9	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
126	**ALE NAN KESYON 115 E KONTWOLE REPONS MANMAN AN.**	**KONTWOLE KI MODIL POU APLIKE**	
	SI **A OU B:** APLIKE MODIL . **DYARE**	MODIL C (DYARE)	→ **129**
	SI **C, D, OU E:** APLIKE MODIL. **IRA**	MODIL A (IRA)	→ **127**
	SI **F, G, H:** APLIKE MODIL **MALARYA**	MODIL B (MALARYA)	→ **128**
MODIL A : TRETMANT TIMOUN AK PWOBLÈM RESPIRATWA			
127	Ki medikaman (non timoun nan) te bwè pou pwoblèm respitatwa? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN.....A ASPIRIN.....B ASETAMINOFÈN..... C AMOKSISIILIN ..... D ERITWOMISIN .....E ANPISILIN.....F KOTRIMOKSAZÒL……..…G LÒT_____ x (PRESIZE) PA KONNEN……..Z	
MODIL B : TRETMAN TIMOUN KI GEN FYÈV			
128	Ki medikaman (non ti moun nan) te bwè pou lafyèv li a? EKRI TOUT SA LI DI. MANDE LI POU L MONTRE W YO.	ANYEN……A ASPIRIN……..B ASETAMINOFÈN ……..…..C KOTRIMOKSAZÒL……D KLOWOKIN ..…… E KININ ..... F LÒT_____ x (PRESIZE) PA KONNEN……..Z	
MODIL C : SWEN TIMOUN AVÈK DYARE			
129	Ki sa (non ti moun nan) te bwè pou trete dyare a ? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN..... A SEWÒM ORAL ..... B PREPARASYON NAN KAY...C GRENN OUBYEN SIWO.....D PIKI..... E PIKI NAN VENN (IV) ..... F REMÈD NAN KAY/ REMÈD TRADISYONÈL…….G LÒT_____ ..... x (PRESIZE) PA KONNEN…… Z	
130	Eske (non ti moun nan) te pran zen pou dyare a ?	NON……1 WI……..……..2 Si WI, pou konbyen jou : __ __	

ANTWOPOMETRI

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
131	Nan sis dènye mwa ki sot pase yo, èske (non timoun nan) te pran medikaman pou vè ?	NON..... 1 WI ..... 2 PA KONNEN 9	
132	MANDE MANMAN AN SI W MÈT KONTWOLE MEZI BRA (non timoun nan). SI LI DAKÒ, EKRI ENFOMASYON ESANSYÈL YO NAN ESPAS KI PI BA YO		

PERIMÈT BRAKYAL

hilimèt

LAVE MEN			
133	Eske lakay ou a gen yon kote espesyal pou lave men ?	NON.....1 WI.....2	→**FIN**
134	MANDE YO POU YO MONTRE W KOTE YO LAVE MEN YO, E GADE SI YO GEN BAGAY SA YO :	**NON WI** (A) DLO/TIYO .....1 2 (B) SAVON/FAB .....1 2 (C) KIVÈT 1 2	
135	Ki lè w lave men w yo ak savon osinon fab? EKRI TOUT SA LI DI.	PA JANM..... ……A ANVAN PREPARE MANJE ..... B ANVAN BAY MANJE/ BAY TETE ...C LÈ W SOT NAN TWALÈT.....D LÈ W FIN N NETWAYE YON TIMOUN KI TE SAL AK TATA …… E LOT_____ 8 (PRESIZE)	

Child Survival and Health Grants Program Project Summary

Oct-13-2006

Concern Worldwide Incorporated
(Haiti)

General Project Information:

Cooperative Agreement Number: **GHS-A-00-05-00018**
Project Grant Cycle: **21**
Project Dates: **(9/30/2005 - 9/30/2010)**
Project Type: **Standard**

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Funding Information:

USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $908,799

Project Information:

Description:

This is a five-year USAID Child Survival & Health Standard Grant Program led by Concern Worldwide, a strategic partnership with Groupe de Recherche et d'Echange Technologique (GRET), and Foundation of Compassionate American Samaritans (FOCAS). Together, these three agencies work hand in hand with the Ministry of Health (MSPP) at the Ministry of Health West Department (DSO) with the aim of improving the health status of vulnerable maternal, child and youth populations living in five disadvantaged urban neighborhoods.
Urbanization and Health. Over the past 15 years the urban population in Haiti has swelled from 29.5% to 38.8% leaving the urban extreme poor as the fastest growing population in the country. While national health indicators have improved over the past 20 years, the urban areas have been particularly affected by unplanned growth and public service neglect. Two-thirds of Port-au-Prince residents earn less than $25 US per month, making it one of the poorest cities in the world.

Insecurity. The past two years have been particularly difficult as the collusion of political violence and economic frustration have resulted in physical violence, mental anguish, population displacement,– and death, things that cannot be described in an opening paragraph. While elections of February 2006 have brought calm and sense of renewal, on March 2006, UNICEF issued a Child Alert for Haiti, marking it as one of the most challenging places on earth for children. Haiti's biggest cities were spotlighted as traps locking mothers and children into a "perpetual cycle of violence, poverty and abuse that is almost impossible to break."

Health Status. Despite overall decline over the past 20 years, the national child mortality rate is among the 40 highest in the world, with infant mortality rate estimated at 74/1,000 and under-five mortality at 117/1,000 . The major causes of mortality for children under-five are pneumonia, diarrhea, and malnutrition. One-quarter of all child deaths occur among newborns during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths. The maternal health status has improved, but the maternal mortality ratio is the highest in the western hemisphere at 523 deaths per 100,000 live births. Major causes of maternal death are hypertension, obstructed labor and hemorrhage. HIV/AIDS prevalence has also dropped over the past 5 years, but remains the highest outside Africa with an estimated adult seroprevalence of 3.5%.

Objectives and Outcomes. The strategic objective of the urban health project is sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching about 10 percent of the city's population. The total project population includes 218,490 residents including 32,555 children under five years of age (including 7,990 infants 0-11 months, 6,227 young children 12-23 months, and 24,565 children 24-59 months), and 53,967 women of reproductive age (15-49 years).

This program focuses on six key interventions which closely match the principle causes of child and maternal mortality: HIV/AIDS (20%), maternal & newborn care (20%), control of diarrheal disease (25%), nutrition (15%), pneumonia case management (10%); and immunizations (10%). Some of the specific population changes expected include:

Improved preventive child health practices
- Increase from 22% to 35% infants age 0–5 months exclusively breastfed during the last 24 hours
- Increase from 51% to 80% children 12-23 months fully vaccinated (verified with card) by first birthday

Improved care for sick child
- Increase from 66% to 75% children 0-23 months with cough and fast, rapid or difficult breathing in past 2 weeks who were seen by trained provider
- Increase from 13% to 50% mothers with a sick child aged 12-23 months who increase fluids and maintain feeding during the illness

Improved maternal and newborn care
- Increase from 70% to 90% mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy
- Increase iron folate intake for 90 days or more by mothers of children aged 0-11 months from 4% to 20%
- Increase from 16% to 35% of mothers of infants 0-11 months who attended postpartum care check-up with the newborn within 7 days of birth

Enhanced youth HIV/AIDS protection
- Increase by 35% the number of youth aged 15 to 24 who become new acceptors of modern contraceptive methods
- Increase from 12.6% to 20% number of sexually active, out-of-union youth, aged 15 to 24 years, who use a condom consistently for the past 3 months

The following intermediate results encompass the strategy and activities required at the household, neighborhood, health service and political level. Together, these will enable the above, long-term goals for improved health to be realized.

IR 1: Empowered communities with increased knowledge and interest in maternal, child

and youth health promotion. Working with 5 neighborhood health networks of numerous active and respected CBOs, 1,136 youth leaders, 60 TBAs and health center personnel, build skills to identify needs, develop strategies and actions for health promotion, resource activities, and monitor effectiveness.

IR 2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas. Working with 5 health facilities, improve availability and management of essential drugs and supplies, leverage availability of subsidized national programs, and learn from strategies from GRET's European Union funded program with mutuelles as well as Child Survival experience in Rwanda with social insurance schemes.

IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers. Working with five focal health facilities to develop a quality assurance and monitoring team approach, develop and test models for performance incentives, organize trainings on key skill areas, organize joint NGO/BC supervision on a quarterly basis.

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people. Developing exchange and applied research platform to build evidence and consensus for effective urban health strategies, documenting and disseminating experience, advocating on environmental health intervention by government and donor community, and supporting DSO in initiating an urban health strategy development process.

Note that in all intervention areas, other agencies are providing health facility based HIV services including STI screening, facility based care and support, PMTCT and VCT services, safe blood, etc. Therefore, this project complements them with a strong youth prevention and integration of HIV services with maternal and newborn care. Indicators related to HIV/AIDS health services are excluded from this project scope but the program will contribute to monitoring for complementary projects in the area.

Location:

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince works in:
*Delmas Commune: St. Martin and Cite Okay-Jeremie
*Petion-Ville Commune: Jalousie and Bois de Moquette in
*Port-au-Prince Commune: Descayettes

Project Partners	Partner Type	Subgrant Amount
FOCAS	Subgrantee	$371,941.00
GRET	Subgrantee	$350,000.00
Ministry of Health West Department	Collaborating Partner	
Subgrant Total		$721,941.00

General Strategies Planned:

Social Marketing
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Learning in Action
Lot Quality Assurance Sampling
Appreciative Inquiry-based Strategy
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
Interpersonal Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	PVOs (Int'l./US)	(None Selected)	National MOH	Health CBOs Other CBOs

Interventions/Program Components:

Immunizations (10 %)

(IMCI Integration)
(HF Training)

- Polio
- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Cold Chain Strengthening
- Injection Safety
- Mobilization
- Community Registers

Nutrition (15 %)

(IMCI Integration)
(HF Training)

- ENA
- Cont. BF up to 24 mos.
- Maternal Nutrition

Pneumonia Case Management (10 %)

(IMCI Integration)
(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (25 %)

(IMCI Integration)
(HF Training)

- Water/Sanitation
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling
- POU Treatment of water

Maternal & Newborn Care (20 %)

(IMCI Integration)
(HF Training)

- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- PMTCT of HIV
- Emergency Transport

HIV/AIDS (20 %)

(HF Training)

- Treatment of STIs
- Behavior Change Strategy
- Access/Use of Condoms
- STI Treat. with Antenat. Visit
- ABC
- PMTCT
- Nutrition
- Home based care
- PLWHA

Target Beneficiaries:

Infants < 12 months:	7,990
Children 12-23 months:	6,227
Children 0-23 months:	14,217
Children 24-59 months:	24,565
Children 0-59 Months	38,782
Women 15-49 years:	33,697
Population of Target Area:	218,490

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0%	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	74	107	69.2%	8.7
Percentage of children age 0-23 months whose births were attended by skilled health personnel	98	225	43.6%	6.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	43	225	19.1%	5.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	31	108	28.7%	8.5
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38	74	51.4%	11.4
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	51	101	50.5%	9.8
Percentage of children age 12-23 months who received a measles vaccine	62	101	61.4%	9.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	4	149	2.7%	2.6
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	47	149	31.5%	7.5
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	38	297	12.8%	3.8
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	133	149	89.3%	5.0

Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**4**	**149**	**2.7%**	**2.6**

Comments for Rapid Catch Indicators

Underweight (weight-for-age)
not included in original KPC due to logistical difficulties but will be assessed during urban nutrition and livelihoods survey in July 2006 for St. Martin, Cite Okay & Descayettes only. Midterm and final surveys will include this WFA indicator for all sub-areas.
In using LQAS method, we further refine age groups for respondent types of rapid catch indicators:
Skilled attendant respondents are mothers with child 0-11 months
Bednet use respondents are mothers with child 12-23 months
HIV/AIDS knowledge is mothers with child aged 12-23 months
Handwashing is mothers with child aged 12-23 months